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VOLUME XII

January-December, 1971

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W72-3500

Volume XII
Number 1
January 1971



JOURNAL of the Mississippi
STATE MEDICAL ASSOCIATION

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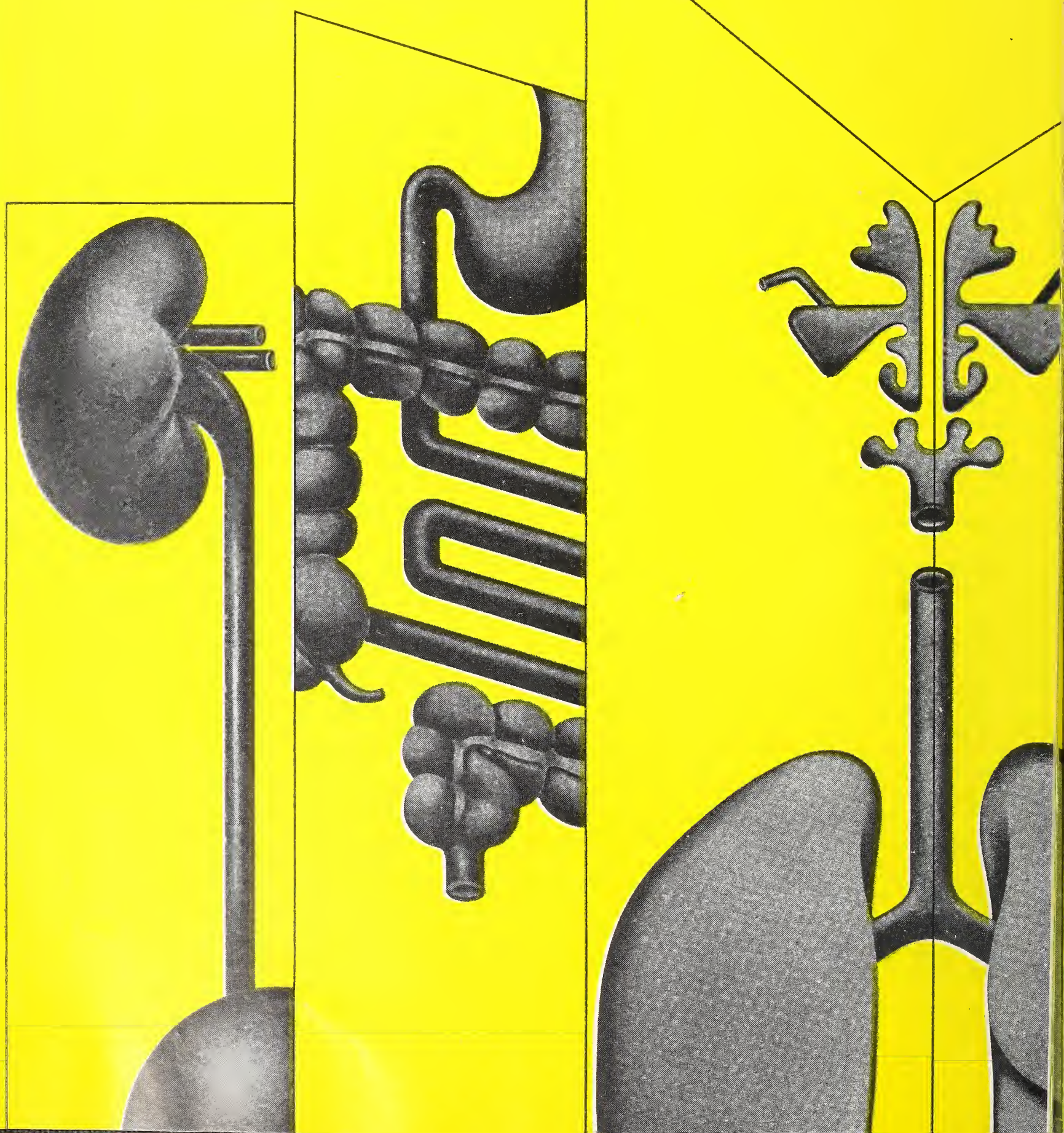
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Tract Record.

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Precautions: Mycotic or bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. Cases of gonorrhea with a suspected primary lesion of syphilis should have darkfield examinations before receiving treatment. In all other cases where concomitant syphilis is suspected, monthly serological tests should be performed for a minimum of 4 months.

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AAP Prevents Lead Poisoning

The major emphasis in programs designed to prevent lead poisoning in children should be on testing household surfaces, both interior and exterior, for lead-pigment paints in order to identify high-risk areas within the community, according to the American Academy of Pediatrics.

In a statement appearing in a recent *Newsletter,* the Academy also strongly emphasizes that the determination of lead in blood should be made for all 12-15 month-old children living in poorly maintained dwellings in identified high-risk areas, "and wherever other special local situations expose children to lead hazards."

The statement, prepared jointly by the Academy's Committee on Environmental Hazards and its Committee on Accident Prevention, further urges that at the very least, a subsequent sample of blood should also be obtained during the following spring or summer.

"Those children with levels of blood lead greater than 50 micrograms per 100 milliliters whole blood should be referred immediately for definitive medical evaluation and a repeat blood lead determination," the Academy statement indicates.

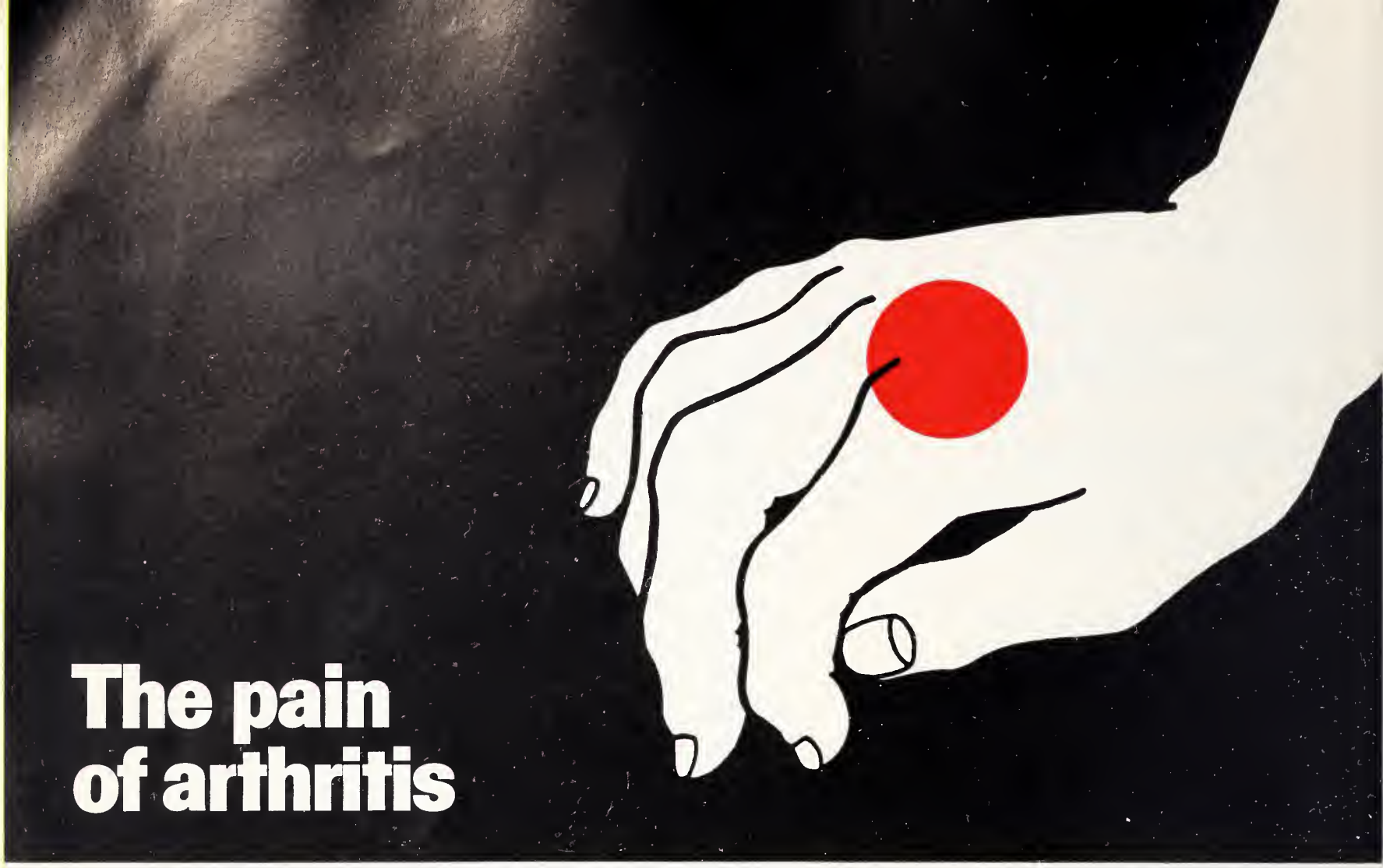
The Academy continues by pointing out that all children having two blood samples with a concentration greater than 50 micrograms per 100 milliliters whole blood should be reported to the responsible local government agency "so their environment can be investigated by appropriate officials and action taken to eliminate the hazard."

"To be effective, these programs must be supported by local health and housing departments with appropriate personnel and laboratory facilities at their disposal," the AAP Committees state.

In calling for these preventive measures, the Academy emphasizes that lead poisoning in childhood is a preventable disease. Virtually all cases occur in children who live in old, deteriorated houses which were built and painted years ago when the use of lead-based paints on housing surfaces was widespread.

The AAP also points out that careful surveys have revealed that 10 to 25 per cent of young children who live in deteriorated urban housing show evidence of increased absorption of lead, and 2 to 5 per cent show evidence of poisoning.

Members of the AAP's Committee on Environmental Hazards recently testified before the Senate and House Banking and Currency Committees in support of legislation to eliminate lead-based paint from housing.



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NEWSLETTER

January 1971

ear Doctor:

he Medicare crossover claim under Medicaid, a thorny issue among D's, is still with us and will apparently remain unresolved. ecent action by Social Security Administration withdrew funds or model program in Mississippi under which Part 1-B Medicare arrier would have generated Medicaid claim for over-65 program ecipients. MSMA has devoted major effort to securing solution.

> Crossover means that practicing physicians must prepare two claims for care of over-65 Medicaid recipients. Further difficulties are encountered in applying Medicare fee differences to deductible and co-pay liabilities of Medicaid. State pays Part 1-B premiums for recipients.

anuary is National Blood Donor Month, and President Nixon has issued proclamation to direct public attention to nation's blood needs. cting on recommendation of Committee on Blood and Blood Banking, tate medical association has asked Gov. Williams and mayors of l Mississippi communities to issue similar proclamations. Many eel that solution to crisis may lie in blood assurance programs.

absolutely nobody's surprise, American Hospital Association's oard of Directors has endorsed Ameriplan. The national health rogram, a consortium of "health care corporations" using private id public financing, was developed by an AHA committee. Basic lea appears to convert existing Blue Cross corporations into ew health care corporations, assuming enactment by the Congress.

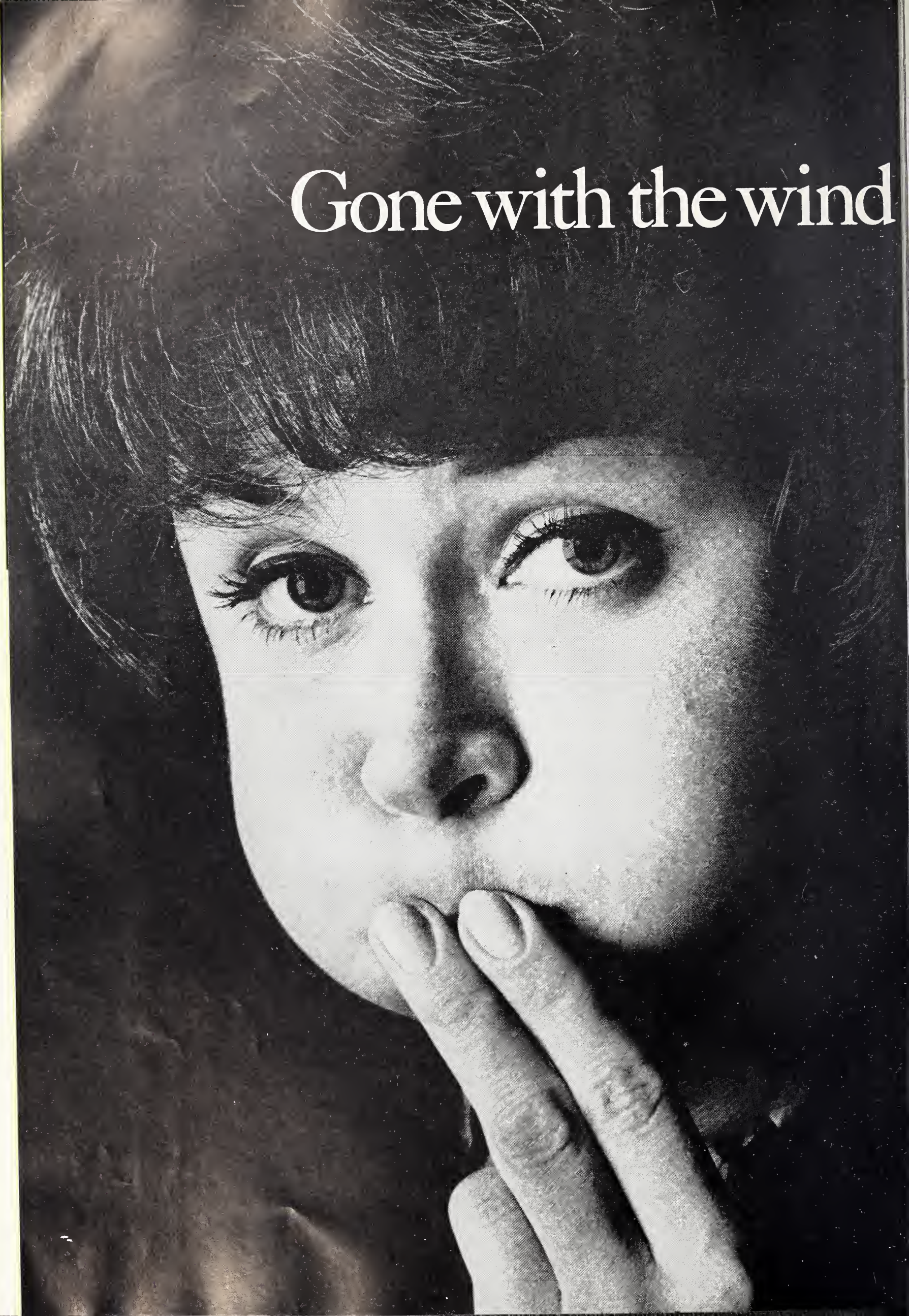
x radio stations have filed suit in D.C. federal court seeking set aside FTC ban on cigarette advertising on radio and tube. asis of suit is FTC discrimination against electronic media, since an does not affect print media. Tobacco industry slickered FTC getting ban to read after Jan. 1, thereby getting on air with ucrative TV fag ads for New Year's Day bowl games.

ew Sheraton-Biloxi will be headquarters for 103rd Annual Session Gulf Coast May 3-6. Change was ordered by Board of Trustees ter receiving report of special survey committee. The new $7 illion facility, state's most luxurious, opens this month. Reembling Americana in Florida, it has cascade pools, hanging gardens, and is destined to become major convention center.

Sincerely,

Rowland B. Kennedy
Executive Secretary

Gone with the wind



RMP Screens Diabetic Siblings

Children with diabetic blood relatives develop diabetes at a much higher rate than do children who do not have diabetic blood relatives, according to a report in a recent issue of the *Disease Detection Newsletter*.

The report highlights the findings of a pilot project started at the University of Missouri's School of Medicine and since Jan. 1, 1970, supported by the Missouri Regional Medical Program.

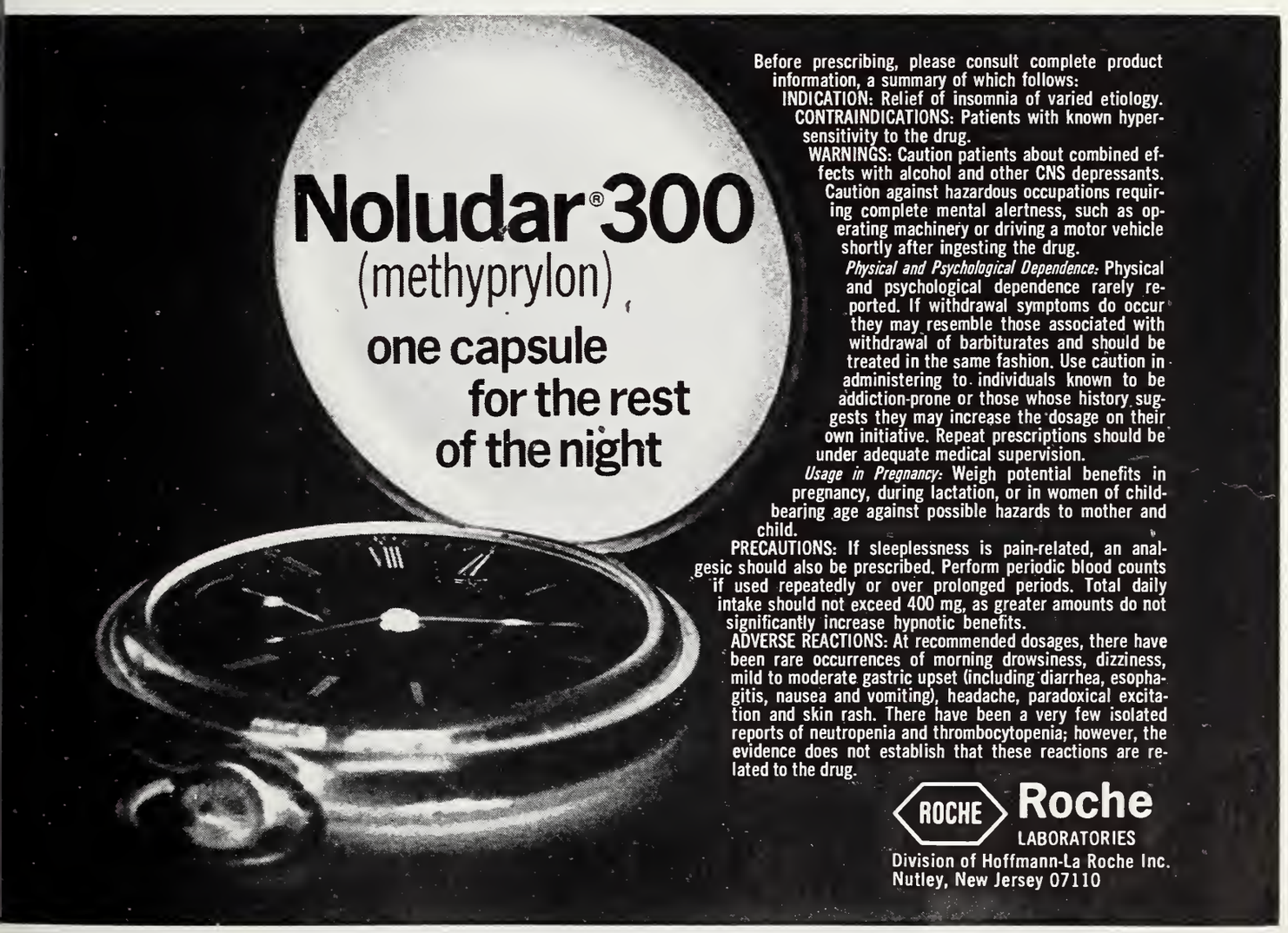
The University's Department of Pediatrics has screened over 2,000 siblings of children with overt diabetes mellitus since 1958, finding that about half of these high risk children have abnormal glucose tolerance tests and that many of them go on to develop overt diabetes mellitus. The incidence of abnormal glucose tolerance tests has also proved to be much higher in children who have diabetes in the family out to third-degree relatives than in children without diabetic relatives.

Three Missouri counties are included in the pilot project. Questionnaires asking for family diabetes history are sent to each family in the county. The project asks to screen youngsters 16 and younger who have diabetic blood relatives closer than the third degree.

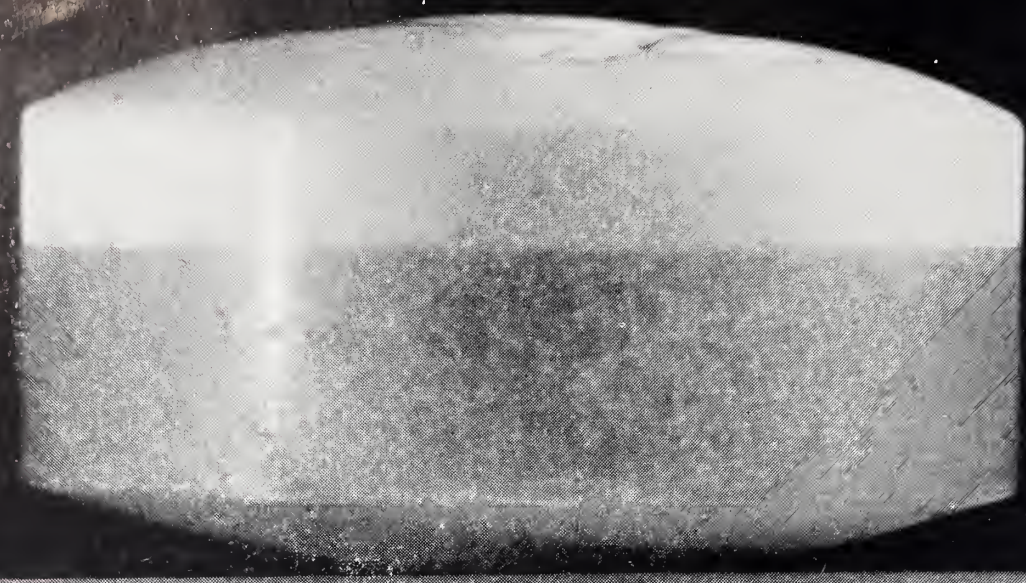
The program's objective is to detect children in a very early chemical diabetic state, where preventive measure will be effective in preventing the youngsters from developing overt diabetes mellitus. The standard three-hour oral glucose test is used to isolate these children from the high risk children who are not in early stage of chemical diabetes.

The children follow a high-carbohydrate diet for three days, then fast overnight. A blood sugar reading is obtained and the child then is given a measured dose of glucose in solution. Fingertip blood samples are obtained at one-half hour and one, two and three hours after glucose ingestion. The blood is analyzed for both glucose and insulin values. Serum insulin results are compared with values obtained from 253 normal youngsters.

In addition to the detection of these early-stage chemical diabetic children, the project includes an education program for diabetic children and their parents, diabetic adults, and medical and nonmedical persons involved in the care of diabetics.



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For reassuring prophylactic imen: "One tablet immediately on ing and 1 tablet 12 hours later—o empty stomach"—provides a simple imen which alleviates medication ieties, and is associated with bo decrease in the number of angina tacks and nitroglycerin tablets.

References: 1. Data on file in the facturing Department of Warner-Chilcott L tories. **2.** Data on file in the Medical Depa of Warner-Chilcott Laboratories.

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Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg has been reported in clinical usage to reduce in number and severity the incidence of angina pectoris attacks, with concomitant reduction in glyceryl trinitrate intake. In the evaluation of Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg in angina pectoris, clinical improvement has been customarily measured subjectively by: reduction in number and severity of attacks and necessity for glyceryl trinitrate intake for prevention or abortion of anginal attacks. Individual patterns of angina pectoris differ widely as does the symptomatic response to antianginal agents such as pentaerythritol tetranitrate. The published literature contains both favorable and unfavorable clinical reports. In conjunction with total management of the patient with angina pectoris, Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg has been accepted as safe for prolonged administration and widely regarded as useful: **Indications:** Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg is indicated for the relief of angina pectoris (pain associated with coronary artery disease). It is not intended to abort the acute anginal episode but is widely regarded as useful in the prophylactic treatment of angina pectoris. **Contraindications:** Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg is contraindicated in patients who have a history of sensitivity to the drug. **Warning:** Data supporting the use of Peritrate (pentaerythritol tetranitrate) during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine, and many other agents. **Precautions:** Should be used with caution in patients who have glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur. **Adverse Reactions:** Side effects reported to date have been predominantly related to rash (which requires discontinuation of medication) and headache and gastrointestinal distress, which are usually mild and transient with continuation of medication. In some cases severe persistent headaches may occur. In addition, the following adverse reactions to nitrates such as pentaerythritol tetranitrate have been reported in the literature: (a) Cutaneous vasodilatation with flushing. (b) Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. (c) An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur with the usual therapeutic doses. Alcoho enhance this effect. **Dosage:** Peritrate SA tained Action (pentaerythritol tetranitrate) (b.i.d. on an empty stomach), 1 tablet in ately on arising and 1 tablet 12 hours **Supplied:** Peritrate SA Sustained Action taerythritol tetranitrate) 80 mg, bottles and 1000 tablets. **Additional Dosage F** Peritrate (pentaerythritol tetranitrate) 10 m 20 mg tablets with or without phenobarb mg, bottles of 100 and 1000 tablets. Pe with Phenobarbital SA Sustained Action— erythritol tetranitrate 80 mg and phenob 45 mg, bottles of 100 and 1000 ta (WARNING: Tablets containing phenob may be habit forming.) Peritrate with Nitr erin—pentaerythritol tetranitrate 10 mg w troglycerin 0.3 mg, bottles of 50 tablets. **Pharmacology:** In a series of carefully de studies in pigs, Peritrate (pentaerythritol trate) was administered for 48 hours bef artificially induced occlusion of a major nary artery and for seven days thereafte pigs were sacrificed at various intervals riods up to six weeks. The result sho significantly larger number of survivors drug-treated group. Damage to myocard sue in the drug-treated survivors was le tensive than in the untreated group. Stu dogs subjected to oligemic shock throug gressive bleeding have demonstrate Peritrate (pentaerythritol tetranitrate) is active at the postarteriolar level, produc creased blood flow and better tissue per These animal experiments cannot be tra to the drug's actions in humans.

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PE-

DATELINE

Judges Hold Key Commitment Fee?

Jackson - The Mississippi Chancellors Association says it will recommend that Legislature authorize an increase in fees paid to M.D.'s for time spent in testifying at hearings for commitment of individuals to mental institutions. Present inadequate fee is $7.50 for expert testimony with nothing paid for pre- and posthearing consultations. State medical association asked chancellors to endorse concept of usual and customary fee for M.D. testimony.

Congress Passes Training Bill

Washington - Mississippi Congressman William M. Colmer, chairman of powerful House Rules Committee, was a central figure in getting S. 3418, the Family Practice Training Act, to House floor for final passage. Measure provides $225 million over three years in grants to medical schools which will organize programs in departments of family practice with status equal to other clinical departments. Measure also funds needed new construction for GP training.

Mitchell Premed Fund at MSU Grows

Starkville - The C. B. Mitchell Premed Fund at Mississippi State University is boasting assets of $30,000 with recent gift of $10,000 IBM shares. Other income is realized from sale of "golden railroad spikes" and square nails from old president's home. Fund also sponsors annual C. B. Mitchell Lecture. Last year, Dr. Alton Ochsner reached 7,500 in the university community on tobacco and health. Lecture this year will be on drug abuse and alcohol.

Computer Enters in Papanicolaou Award

Los Angeles - Dr. George L. Wied, professor of ob-gyn at University of Chicago, had a silent partner in his work which won him the George Papanicolaou Award. Dr. Wied devised refined differential diagnosis techniques on tissue cells by teaming microscopic examination with computer programming. Result was "super consultant" in form of computer support for diagnostic work. System is said to enhance detection of benign characteristics.

Capital Has Major Drug Abuse Problem

Jackson - The December term of the Hinds County grand jury rocked complacency out of Jacksonians when it found 90 of 272 true bill cases related to drug abuse or illicit agents. Cases range from simple pot possession to criminal cases involving drug usage and traffic. District Attorney Jack Travis said that this was largest number of drug cases ever before a grand jury in capital city. He warned that drastic measures must be taken to curb abuse and related crimes.

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Side effects: Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

Dosage: Adults: One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms. Children 2 to 12 years: One half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

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and the Latin **sedatus,**
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Human Life Ruled By Biological Clocks

Scientific evidence from biomedical research shows that man is constructed not only of matter, but that he is also a creature of time, dependent upon unseen biological clocks, organized down to his cells according to temporal mechanisms, and bound to subtle, fluctuating rhythms in health and in disease.

This is the theme that emerges from a major new research report issued by the Health Services and Mental Health Administration's National Institute of Mental Health, focus of the government's attack on mental illness.

The Institute has pioneered a wide spectrum of biological rhythms research, in its own laboratories and through grant support. These range from the testing of new drugs and procedures to clinical and public health programs. This research is exploring previously untouched as well as old areas of the once neglected but now burgeoning field of biological rhythms and their relevance to man's health.

"From the moment of conception until death, rhythm is as much a part of our structure as our bones and flesh," says Dr. Bertram S. Brown, Director of the NIMH, in his introduction to the report.

"Most of us are dimly aware that we fluctuate in energy, mood, well being, and performance each day, and that there are longer, more subtle behavioral alterations each week, each month, season, and year.

"Through studies of biological rhythms, many aspects of human variability, in symptoms of illness, in response to medical treatment, in learning and job performance, are being illuminated.

"As a result, timing promises to become an important factor in preventive health programs and medicine. For example, since the effects of drugs depend in part upon the time of administration, timing may be used as a critical aspect of treatment. X-ray treatments, surgery, and even psychotherapy may be influenced in their outcome by timing."

Titled, "Biological Rhythms in Psychiatry and Medicine," the 183 page report was prepared by the Program Analysis and Evaluation Branch, Office of Program Planning and Evaluation of NIMH.

"Biological Rhythms in Psychiatry and Medicine," NCMHI Publication No. 2088, is available at $1.75 per copy from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20203.

Brief Summary of Prescribing Information– 9-9/22/69. For complete information consult Official Package Circular.

Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

Usual Dose: 1 tablet b.i.d.

Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

Salutensin®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
January 1971, Vol. XII, No. 1

ORIGINAL PAPERS

Leukemia and Viruses

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There is much documented literature supporting the theory that human leukemia is of viral etiology. The biggest and oldest supportive evidence is that viruses cause animal leukemias. The author shows that leukemia resembles a viral disease at onset and seems to be an infectious process. He discusses the work of such researchers as Ellerman, Bang, Rous, Bittner, and Rauscher.

SCIENTIFIC DISCOVERIES, even those based on the soundest proof, often do not fare well if they are made before their time. One can easily remember Semmelweis who practiced strict aseptic procedures in his maternity ward and demonstrated that this was quite effective in reducing deaths attending childbirth. He quite naturally attempted to tell other physicians this good news. Everyone knows the outcome: for his pains, his ideas were rejected and he died a man driven insane because no one would listen.

This is not a phenomenon restricted to past eras of history. As recently as 1947, when Avery described his proof that DNA was the molecule with the genetic information, he, too, was ridiculed. As time has passed, however, Semmelweis's and Avery's works have been recognized. The times of aseptic procedures and of DNA have already arrived.

A recent article by Richard Shope[1] about the early work of Ellerman and Bang, and of Peyton Rous jumps back to the early 1900s. Shope comments:

> "In 1908, Ellerman and Bang, working in Denmark, demonstrated a virus as the cause of leukemia in chickens. This observation did not attract the attention it deserved from the standpoint of cancer research, because at the time leukemia was not generally thought of as a cancerous process. It remained for Rous in 1911[3] to discover the first virus-caused solid tumor. This was a sarcoma of chickens. The agent responsible for inducing the growth had all the characteristics of a filterable virus, and the growth itself was a true malignant tumor which metastasized and eventually killed its hosts. This discovery by Rous is generally designated as the event that introduced the era of viral tumors.
>
> "Among oncologists of the day, the immediate reactions to Rous' finding and its interpretation were violent and critical. While few could deny that the fowl sarcoma looked like

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Presented at UMC Cancer Conference, October 29, 1969, at Jackson.

a true neoplasm, some contended that, because it was a tumor of a bird, it was in quite another category than would be a mammalian tumor and hence was meaningless from the standpoint of cancer. Also it was argued that the very fact that an extrinsic causative agent could be demonstrated served to indicate that the growths produced in chickens could not be true tumors and that, even though they looked and acted like cancers, they had to be considered as something different and apart from them. Rous has told me of the visit of a distinguished British oncologist to his laboratory in the early days. This man, when shown a fine example of the chicken tumor, is supposed to have said 'But my dear fellow, don't you see, this cawn't be cancer, because you know its cause.' "

It took more than 50 years for the rest of science to catch up with Rous. He finally was awarded the Nobel Prize last year and even in the past five years more than one reviewer has approached the subject of viruses as a cause of human cancer with tongue in cheek. Koprowski,[4] in the Harvey Lectures of 1964-65, titled his talk "The Emperor's New Clothes, or an Inquiry Into the Present Status of Tumor Viruses and Virus Tumors." Critics notwithstanding, however, I believe that the time of viruses and tumors is at hand.

The first question we might ask at this point is: How do you prove that leukemia is caused by a virus? At the outset I should say that I think we ought to abandon Koch's postulates and turn to our friend the scientific hypothesis which rises and falls on appropriate data. The reason Koch's postulates do not apply is that animal viruses interact with a host in a variety of ways, as shown in Figure 1.

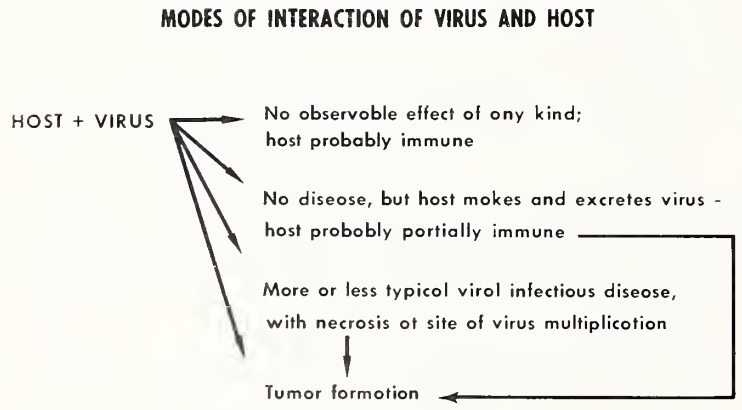


Figure 1

Koch's postulates depend on a single clinical response to the agent. This simply does not apply in the case of tumor viruses. Besides, the postulates were made before viruses were discovered. There are at least two other limitations. The first is that the virus as such that caused the tumor may not be present any longer; the second is that it may be present but nearly impossible to find because we don't know how to look for it. Then how do we show that leukemia is or is not caused

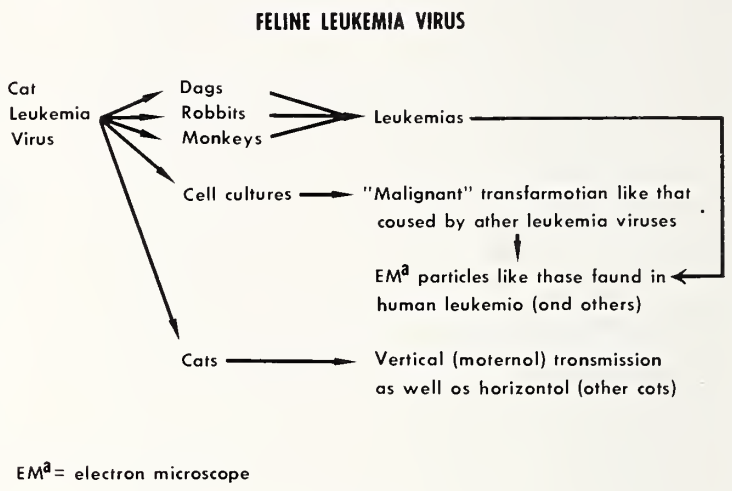


Figure 2

by a virus? We need a hypothesis which includes the pertinent data, and which can be tested in some meaningful way.

Let us examine some of the evidence for a viral etiology of human leukemia. The case is built on a foundation of bits and pieces of varying sizes, and capped recently with two remarkably exciting groups of experiments. First let us examine some of the bits and pieces.

(a) Perhaps the biggest and oldest bit of evidence is that viruses cause animal leukemias. There is simply no good reason to suppose that man is different from other animals, and that human leukemia should not be caused by a virus. I do not need to describe these experiments, but I can mention a few of the key experimenters: Ellerman, Bang, Rous, Bittner, Rauscher, Gross, Moloney and Friend.

(b) The second piece of information is that human leukemia simply very often looks like a viral disease on its onset. Consider a recent description of the onset of acute leukemia:

> Symptoms often appear abruptly in acute leukemia with fever, prostration, rapidly developing pallor, bone or joint pain, bleeding from mucous membranes or into skin, sudden enlargement of lymph nodes or ulceration in the oral cavity.[5]

The onset of influenza was described as:

> The prostrating effects of influenza are associated with fever, chilly sensations (seldom with rigors), headaches and myalgia. Fever usually exceeds 101°F. and may reach 106°F. It is usually abrupt in its onset and decline and lasts for only two to five days in the absence of complications.[6]

There are some differences, of course, but much in common. There are a few smaller but nevertheless interesting bits:

(c) In the immune deficiency diseases, particularly hypogammaglobulinemia, in which the patient cannot make much antibody to protect against infectious agents, there is a greatly increased incidence of leukemia. It seems that leukemia represents an infectious process.

(d) "Outbreaks" of leukemia have occurred in institutions. Several victims in a single high school class, came down with the disease for example, in much the same way that people would with a standard infectious disease, except on a smaller scale. Leukemia appears to represent an infectious process.

IMMUNE RESPONSES

(e) In 400 kidney transplants treated with antilymphocyte serum or other immunosuppressants to suppress the host immune response so the kidney would not be rejected, there developed 15 cases of lymphoma,[7] an astronomical incidence. The message is that lymphoma represents an infectious process; in this case, of course, the message could also be interpreted that the immune response ordinarily functions to kill cancer cells and is a sort of internal security committee against cancer.

(f) Two recent exciting experiments are shown in Figures 2 and 3.[8] It is tempting to say that Feline leukemia virus causes human leukemia, but the best interpretation for the time being

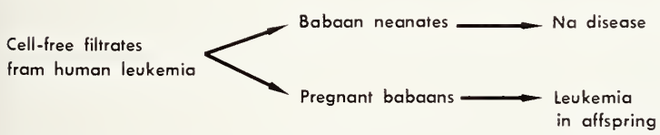


Figure 3

anyway, is that it probably could cause all human leukemia under certain conditions. In Figure 3 there is a more likely candidate for a major cause of human leukemia. At this point we could probably say that the basic experiments to prove the viral etiology of human leukemia have been done, but will have to be repeated and extended.

TABLE 1

TWO COMPONENT SYSTEM OF IMMUNITY

	HUMORAL	CELL
Mediated by	Peyer's patches	Thymus
Expressed by	Antibadies	Certain lymphacytes
Typical function	Neutralize taxins, apsanize bacteria	Rejectian of organ transplant
Functian in leukemia	Immunity to virus	Rejection of tumar cells
Deficiency diseases	Agammaglabulinemia	DiGeorge's syndrame

A few concepts which should be defined before discussing some implications are:

(a) Immune tolerance which is what keeps us from making antibodies to ourself, and from rejecting our own tissues. This is specific, and must be learned by the fetus.

(b) Some of the features of current concepts of cell and humoral immunity are seen in Table 1.

(c) Immunosuppression is what the transplant surgeon tries to do after the surgery. To do it properly is a problem, because we do not have a way of suppressing a specific part of the immune response. I shall use it in the model to mean a general depression of the immune response, both cell and humoral, brought about by whatever means.

HUMAN LEUKEMIA MODELS

(d) Models of human leukemia as a virus disease are shown in Figures 4 and 5. They are only speculative and are included for purposes of discussion.

(e) Manipulation of the mode is the final concept. Once the identity of the agent of human leukemia is established, it should be possible to make a vaccine and immunize the population. There are relatively standard ways of making such vaccines, but they would have to be tested rigorously, of course. One might also, in treating leukemia with chemotherapy, incorporate antiviral agents such as amantadine, which will prevent the spread of virus inside the patient. A characteristic of viral tumors is that all those caused by the same virus have similar antigens on the tumor cell. It ought to be possible in some way to stimulate the cell-mediated part of the immune response to respond to this or other tumor specif-

ic antigens and make the patient reject his tumor.

In conclusion, I should like to quote again from Shope.[1]

> "Those who view a viral etiology as likely, in at least certain human cancer, base their presumptions largely on our current knowledge of the viral tumors of animals. Their rationale is that, with so many examples of viral tumors of animal tumors now known, we have reached a point where it is difficult to bring forth any logical or philosophical reason for any longer considering man a species apart from other animals as regards the causation of his tumors. A number of the proven viral tumors of animals imitate the behavior of human tumors of unknown etiology in their patterns of metastasis; in the manner they regress or kill; in the influence of hormones on their progress; and, some of them, at least, in the comparative ages at which they tend to appear.
>
> "We have reached the point where it is no longer realistic to contend that human cells are different from the cells of other species of animals in their capacity to react to cancer-causing viruses. It would be strange indeed if an etiological line of distinction should exist between tumors of animals, many of which are known to be of viral etiology, and those of man, all of which, at the moment, are of unknown etiology. There can be no doubt that it has been proven repeatedly in the work with animal and bird tumors that viruses are capable, in the intact host, of inducing malignant transformation in cells of many types. On scientific grounds, there is no apparent reason for doubting that, similarly, they can also induce malignant changes in human cells in the intact human host." ★★★

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Supported in part by USPHS grant No. T12 CA 08051-04 CCG.

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MODEL OF HUMAN LEUKEMIA

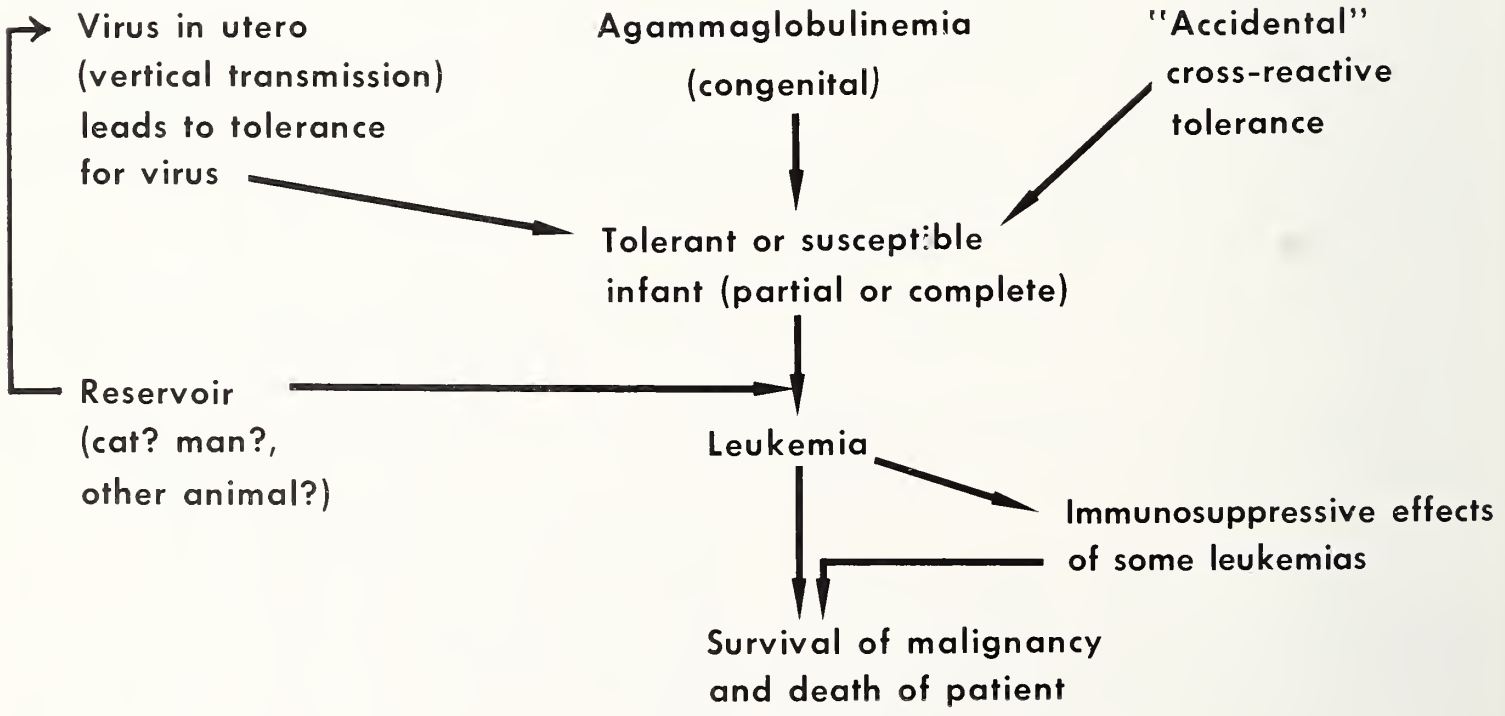


Figure 4

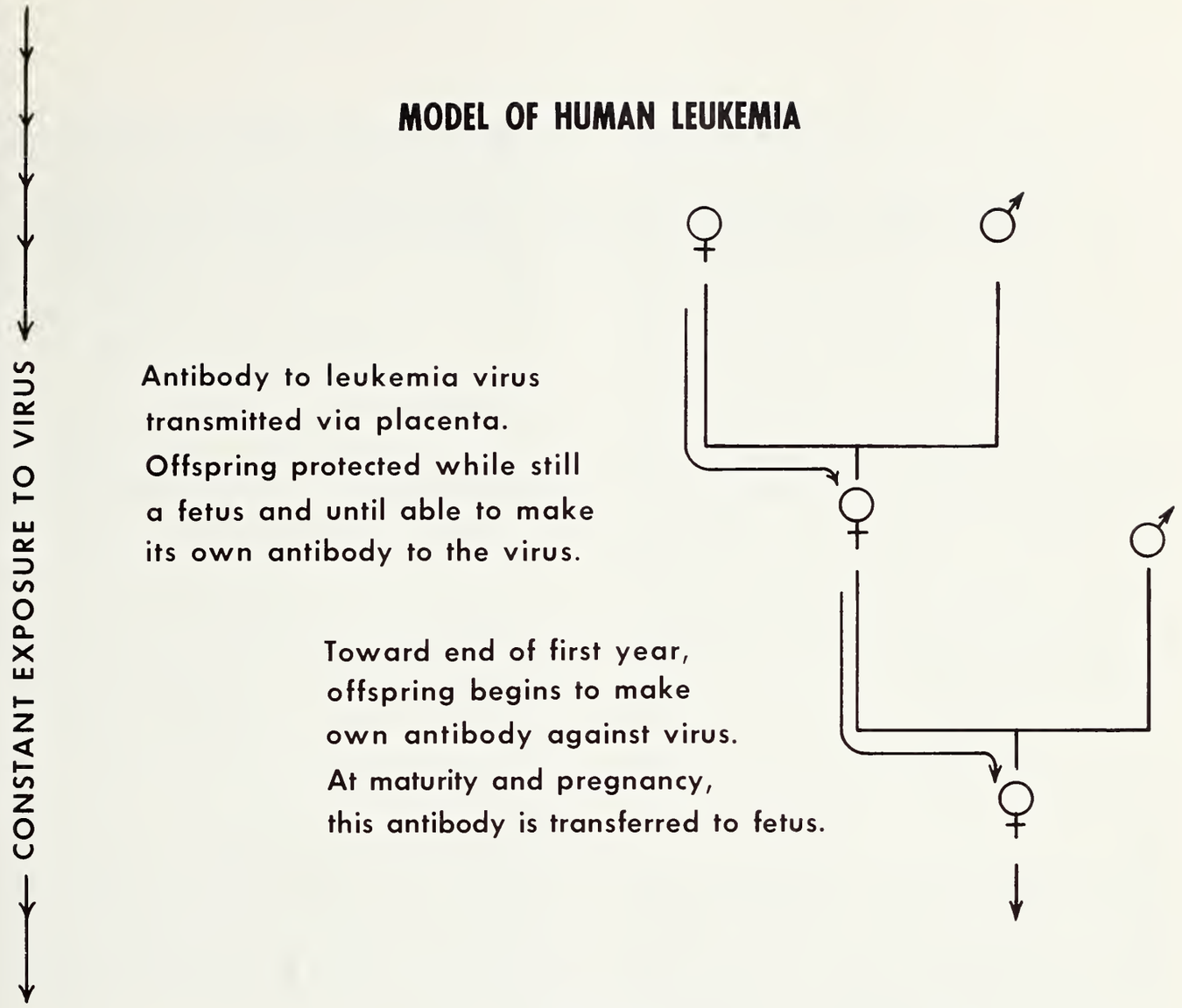


Figure 5

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THE WORD FROM UNCLE

There's got to be a lesson in this:
—The Lord's Prayer consists of 56 words.
—Lincoln's Gettysburg Address has 266 words.
—The Ten Commandments contain 297 words.
—The Declaration of Independence is exactly 300 words.

The recent revisions in regulations for Extended Care Facilities under Medicare issued by the Social Security Administration contain 29,678 words.

Views of Practicing Physicians on the Mississippi Medicaid Program

In late August 1970, the General Legislative Investigating Committee of the Mississippi Legislature requested the state medical association to confer with it in connection with the Mississippi Medicaid Program. At the committee hearing on September 1, the association was represented by its president, Dr. Paul B. Brumby of Lexington, and three executives.

During a general discussion of the Medicaid Program, the committee requested the state medical association to examine into physician attitudes on the program and to discover certain other information to assist the committee in its deliberations:

(1) Extent of physician participation in Medicaid.

(2) Attitudes on fees paid for professional services by physicians.

(3) Comment, suggestions, and recommendations on the program by practicing physicians.

The General Legislative Investigating Committee, in its request and charge to the association, expressed awareness of problems in the program, the need for care of the indigent sick, and the need for coordination of program operation among all concerned in the state to reach the maximum potential of health care delivery within the framework of the enactment.

The association agreed to work with the committee and to furnish the information requested.

Medicaid Program

Medicaid is a federal-state partnership program which has the purpose of delivering medical care to the categorically indigent and near-needy. The federal enactment is Public Law 89-97, Social Security Amendments of 1965, Title XIX. The same law also established Medicare, Title XVIII, a totally federal program for those over age 65.

As with any other welfare title under the Social Security Act, Medicaid may not be brought into being unless a state wills it so and the Legislature acts affirmatively to implement it. Title XIX provides that a state failing to implement Medicaid by January 1, 1970, will no longer receive federal matching funds for medical care under the old vendor titles, I (Old Age Assistance), IV (Aid to Families with Dependent Children), X (Aid to the Blind), and XIV (Aid to the Permanently and Totally Disabled). The Mississippi enactment was passed by the 1969 Extraordinary Session of the Legislature to become effective January 1, 1970. Initially, the program was funded for the second half of Fiscal 1970 (January 1-June 30, 1970).

Based on an economic criteria formula related to state resources, federal matching for Medicaid ranges from a minimum of 50 per cent to a high of 83 per cent. Mississippi qualifies for the latter. For the second half of Fiscal 1970, this is as follows:

Total	*Federal*	*State*
$17,192,499	$13,758,274	$3,434,225

The annual program will require about $41 million as authorized in the enactment. Implementation was completed July 1, 1970, with the inception of the drug program and certain other services which were developed during the first six months.

Position of the State Medical Association on Medicaid

The Mississippi State Medical Association supported implementation of Medicaid as a realistic

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A study made by the Mississippi State Medical Association for the General Legislative Investigating Committee of the Mississippi State Legislature.
The study report is dated Dec. 9, 1970.

ABOUT THE STUDY

The Mississippi legislature, through its joint General Legislative Investigating Committee, keeps a finger on the pulse of all state programs. During routine consideration of the operation of Medicaid, the joint committee requested the state medical association to present the private practitioner's view on the new health care program.

The membership was surveyed in November, and the response was among the best ever received from an association canvass for opinion and suggestions. So that every member of the association may see the report of the study as it goes to the legislature, the decision was made to publish it in the JOURNAL.

As stated in the report, the association gathered a substantial file of data from which much more detailed listings may be made. Component medical societies, local medical groups, or members desiring further information as to detailed findings may address such requests to the association.

It is important to note that the study report contains no formal recommendations on the Medicaid program in the name of the association. In preparing the report, it was the purpose of the Council on Medical Service and Board of Trustees to avoid editorializing on the views and opinions of the respondent-members. Any recommendations with respect to Medicaid for consideration by the legislature will, however, come from appropriate official bodies of the association acting within the framework of established policy.

The Board and the council have expressed appreciation to the membership for the excellent response and the many constructive suggestions, recommendations, and comment on the Medicaid program.—*The Editors*

and effective means of delivering health care to the indigent. In 1967 and 1968, the association conducted an educational campaign on the program, including the conduct and sponsorship of nine regional meetings throughout the state and the production of pamphlets and other informational literature. The association continues in this support and desires to work with state government and others for the success of Medicaid.

STUDY METHOD

The association recognized that a survey of practicing physicians would be necessary to assemble factual information desired by the General Legislative Investigating Committee. Approximately 60 days were available for the project which was divided into four phases:

(1) Study design.

(2) Survey development and questionnaire pretest.

(3) Survey of all members of the association.

(4) Data processing, evaluation of response, and preparation of report.

The survey questionnaire was mailed first class to 1,422 members of the association with a letter of transmittal and a postage-paid return envelope. Over 750 returns were received of which 689 were usable for valid study purposes, a response of 49 per cent. This is more than adequate to assure statistical validity. There is sufficient geographic spread and representation in the response pattern and comparability in control areas to project an error probability of only about $\pm$ 2 per cent. The data were processed on the association's IBM System/360 computer.

The entire project was funded by the state medical association with no external support.

Survey Content

The survey questionnaire was mailed to all members of the association which includes those not eligible to participate in Medicaid. This fact was recognized in the letter of transmittal, calling attention to these categories, i.e., preventive medicine (public health), employed physicians in certain medical institutions, and those in a training status.

Respondents were encouraged not to identify themselves other than to furnish:

(1) County in which practice is conducted.

(2) Specialty.

Five queries were posed, three of which could be answered objectively in the affirmative or negative and two requiring subjective responses:

MEDICAID STUDY

(1) Do you participate in the Mississippi Medicaid Program by accepting patients and filing claims? (Objective)

(2) If you do not now participate, have you ever participated by filing one or more claims since the program began? (Objective)

(3) If you do not now participate, please state briefly why you do not. (Subjective)

(4) Regardless of whether you participate, what changes and improvements do you recommend in Medicaid? (Subjective)

(5) If you do not now participate, would you participate in Medicaid if the changes you recommend were incorporated in the program? (Objective)

Files and Data

The IBM punch cards prepared from coded returns have been retained together with computer printouts in the files of the association. From these data and files, an almost infinite variety of information may be developed, i.e., by medical specialty per county, ratios of participating physicians per area of Medicaid eligibles, etc.

The primary thrust of the study report is to underscore salient facts and major points. Those interested may have access to the data and files. The questionnaire returns are also on file and available for reference.

Finally, subjective comment and recommendations were so massive with 774 written items on 563 returns that reproduction and reporting in toto were not practical. These were classified and categorized for convenience in evaluation and summary reporting.

FINDINGS

Three out of four practicing physicians in Mississippi report that they accept Medicaid patients and file claims. Table 1 presents these data:

(1) Seventy-seven per cent of respondents participate in the program.

(2) Twenty-three per cent of the replying physicians do not now participate. This reply was made at a time when the program has been operational for 11 months.

(3) Fifteen per cent of the respondents have participated at some time by filing one or more claims but do not now participate.

(4) Eight per cent have never participated.

Reasons for Not Participating

Dozens of reasons for not participating in the program were submitted by survey respondents. To assist in evaluating these reasons, four groupings were made by classifications of comment:

(1) *Low fees.* Almost half of those physicians who do not participate—46 per cent—gave low fees paid as the primary reason for not accepting Medicaid patients and filing claims.

TABLE 1
PHYSICIAN PARTICIPATION IN MEDICAID

Item	*Number of M.D.'s*	*Per Cent of M.D.'s*
Total usable replies	689	100
Participate in Medicaid accepting patients and filing claims	530	77
Do not participate and do not accept patients and file claims	157	23
Do not now participate but have in the past	103	15
Have never participated	53	8

(2) *Too much paperwork.* More than a third of these respondents—37 per cent—submitted a wide variety of subjective comment on excessive paperwork associated with claims preparation, filing, correspondence, reports, and administration.

(3) *Opposed to program.* One out of nine respondents in this classification said that they were generally opposed to Medicaid. These comments ranged from philosophical opposition to charges that recipients abuse the program.

(4) *Other reasons.* Six per cent gave a variety of other reasons for not participating in Medicaid which covered minor points to such areas as slowness of claims payment.

Table 2, following, classifies these response groupings.

TABLE 2

REASONS GIVEN FOR NONPARTICIPATION IN MEDICAID

Item	*Number of M.D.'s*	*Per Cent of M.D.'s*
Total M.D.'s not participating in Medicaid	157	100
Reasons		
Low Fees	72	46
Too much paperwork	58	37
Generally opposed to Medicaid	17	11
Other reasons	10	6

Recommendations for Program Improvements

Most respondents submitted comment concerning program changes and improvements. On-

ly 126 respondent physicians did not make such comment. These are summarized in Table 3:

(1) *Reduce paperwork.* The largest single category of comment—190 written items or 25 per cent—urged that claim forms be simplified and paperwork related to the physicians' portion of the program be reduced.

(2) *Fees.* Two classifications representing 38 per cent of written comments relate to fees paid for professional services rendered under Medicaid:

(a) *Usual and customary.* Twenty-three per cent of the comment urged payment of usual and customary fees under Medicaid in Mississippi. This is the form of payment endorsed and approved by the American Medical Association and the Mississippi State Medical Association. It may be generally defined as the "going" or "regular" rate of professional compensation. It is determined by area profiles of charges and subject to peer review by medical organizations.

(b) *Better fees.* Fifteen per cent of these respondents urged payment of "better fees" for services rendered under the program, not necessarily stating how much better.

(3) *Program abuse.* Eight per cent of the suggestions concerned patient abuse of Medicaid, ranging from general statements to actual examples of former private paying patients now under the program.

(4) *Program limitations.* Seven per cent charged that the amount of medical care is limited under the program, stating that services *or* diagnosis and treatment were questioned and that such limitations should be removed.

(5) *Claims processing.* Seven per cent said that claims should be processed and paid more promptly.

(6) *Medicare crossover.* Four per cent stated that the problem of Medicare crossover claims (under which Medicaid pays the deductible and co-pay amount for Title I (OAA) beneficiaries and has required preparation of two claims) was objectionable.

(7) *Other comments.* Twelve per cent of the written comments and recommendations were of a general and constructive nature and mostly of minor administrative interest.

Ninety-three physicians, who state that they do not now participate, would participate in the program if these improvements and changes were made.

Twenty-six physicians said that they will not participate whether changes and improvements are made or not.

TABLE 3

RECOMMENDATIONS FOR MEDICAID IMPROVEMENTS

Item	*Number of Subjective Recommendations*	*Per Cent*
Total written recommendations	774	100
Recommendations		
Reduce paperwork	190	25
Pay usual and customary fees	179	23
Pay better fees	105	15
Recipients abuse program	65	8
Program limits services *or* diagnosis and treatment are questioned	56	7
Pay claims more promptly	53	7
Solve Medicare crossover problem	32	4
Other subjective comment	94	12

Ninety-three M.D.'s said they would participate if improvements were made, whereas they do not now participate.
Twenty-six M.D.'s said they will not participate with or without improvements.

Participation in Medicaid by Specialities

There are 20 major specialties in medicine, each represented by a certifying board to which eligible physicians may apply for examination and certification. There are various sub-specialties, i.e., pediatric cardiology, but for purposes of this study, only the principal American boards and specialties are considered. The American Board of Family Practice (general practice) is the most recently organized, and this discipline is now recognized as a specialty.

Survey respondents were classified by specialty as to program participation. There are 10 medical specialties and 10 surgical specialties.

There is a higher rate of participation in Medicaid by nonsurgeons than by those who do surgery:

(1) Among eight of the 10 nonsurgical disciplines, almost eight out of 10 M.D.'s participate, 78 per cent.

(2) Among eight out of 10 surgical specialties, two out of three M.D.'s participate, 67 per cent.

Tables 4 and 5 present details of participation by medical and surgical specialties. By way of explanation, the medical discipline of physical medicine and rehabilitation is not represented among association membership. Those in preventive medicine (public health) are not engaged in practice and are consequently not eligible to participate in the program.

Among the surgical specialties, no replies were received from those limiting their practices to colon and rectal surgery or to thoracic surgery. There are very few of each, and it is postulated that a number of general surgeons who perform thoracic surgery classified themselves in the response form in the general field.

Participation by Medical Specialties

(1) Almost nine out of 10 anesthesiologists (86 per cent) participate.

(2) Dermatologists participate at the rate of 88 per cent, nearly nine out of 10 in the specialty.

(3) Eighty-four out of 100 family practitioners, the largest single specialty in medicine, participate (84 per cent).

(4) The lowest rate of participation—55 per cent—is among those in internal medicine.

(5) Pathologists, who usually practice within the hospital environment in laboratory medicine participate at a rate of 75 per cent.

(6) Eighty-four per cent of the pediatricians participate in the program.

(7) Less than two out of three psychiatrists participate, 64 per cent.

(8) The highest percentage of participation is among radiologists, 89 per cent, who usually practice in a hospital environment.

Participation by Surgical Specialists

(1) Only one out of three neurological surgeons participate, 33 per cent.

(2) About three out of four obstetrician-gynecologists participate, 73 per cent.

(3) Ophthalmologists, who perform a high rate of nonsurgical as well as surgical services, have the highest participation rate in the surgical category, 82 per cent.

(4) Eight out of nine orthopedic surgeons (79 per cent) participate.

(5) About half of the otolaryngologists (52 per cent) participate.

(6) Two out of three plastic surgeons (66 per cent) participate.

(7) Three out of four general surgeons, the largest surgical specialty, participate (76 per cent).

(8) Three out of four urologists (76 per cent) participate.

TABLE 4

PARTICIPATION BY SPECIALTIES

Nonsurgical Specialty	*Total Replying*	*Participates*	*Do Not Participate*
Anesthesiology	14	12	2
Dermatology	9	8	1
Family Practice	290	240	50
Internal Medicine	69	38	31
Pathology	4	3	1
Pediatrics	37	31	6
Psychiatry and Neurology	14	9	5
Radiology	18	16	2
Physical Medicine	—	—	—
Preventive Medicine	—	not eligible	—

TABLE 5

PARTICIPATION BY SPECIALTIES

Surgical Specialty	*Total Replying*	*Participates*	*Do Not Participate*
Neurological Surgery	3	1	2
Obstetrics and Gynecology	49	36	13
Ophthalmology	33	27	6
Orthopaedic Surgery	24	19	5
Otolaryngology	19	10	9
Plastic Surgery	3	2	1
General Surgery	80	61	19
Urology	17	13	4
Colon and Rectal Surgery	—	—	—
Thoracic Surgery	—	—	—

Selected Geographic Areas

In evaluating the study data, certain selected areas of the state were studied with regard to (a) high impaction of Medicaid recipients and (b) presence of major medical centers in terms of professional personnel and facilities. Mathematically, it is possible to derive thousands of tabular listings and comparisons of participation, ratios of participation to numbers of recipients, relations to physician population and medical facilities, and the like.

Production of these facets would contribute little to the present study effort, while requiring a disproportionately great investment of time and expenditure of funds. Certain selected comparisons of physician participation by geographic area are reported in Table 6:

(1) An area of highest physician participation is the grouping of Bolivar, Coahoma, and Sunflower counties where there is a high impaction of Medicaid eligibles. The rate is about 93 per cent.

(2) Two areas of lowest physician participation are east Mississippi and the Gulf Coast. Lauderdale County has a rate of 43 per cent, while the three Coast counties have a rate of 47 per cent. Both are in contrast to the statewide rate of 77 per cent.

TABLE 6

PARTICIPATION BY SELECTED GEOGRAPHIC AREAS

Selected Area	*Total Replying Area*	*Participate*	*Do Not Participate*
Alcorn County	11	6	5
Bolivar, Coahoma, and Sunflower counties	28	26	2
Lee County	30	25	5
Washington County	24	17	7
Hinds County	169	119	50
Lauderdale County	21	9	12
Forrest County	35	26	9
Hancock, Harrison, and Jackson counites	66	31	35

(3) An example of an isolated pocket of low physician participation is Alcorn County with 55 per cent adjacent to Lee County with 83 per cent.

(4) Three large counties, Washington, Hinds, and Forrest, with major physician populations and medical facilities approach the state mean with 71, 70, and 74 per cent respective physician participation rates.

SUMMARY AND CONCLUSIONS

The study inquires into three areas of concern among practicing physicians in Mississippi with reference to the Medicaid program:

(1) Physician participation.

(2) Fees paid.

(3) Comment, suggestions, and recommendations.

Participation

Three out of four Mississippi physicians state that they participate in Medicaid by accepting patients and filing claims.

One out of three physicians does not participate.

One out of six has participated at some time previously but does not participate now.

One out of 12 has never participated.

Reasons for Not Participating

Half of the physicians who do not participate give the low fees paid as the reason.

A third of the nonparticipants say the reason is too much paperwork.

One out of nine physicians is opposed to Medicaid.

A few submitted other reasons for not participating, including slowness of claims payment.

Recommendations for Program Improvements

Reduce paperwork for practicing physicians in preparing, filing, and reporting on claims.

Pay better professional fees, preferably under the concept of usual and customary fees.

Eliminate abuse of the program by patients.

Relieve limitations imposed on amount of medical care needed by the patient.

Process and pay claims promptly.

Eliminate dual claims procedure in Medicare crossover.

Participation by Specialties

More medical than surgical specialists participate in Medicaid. Eight out of 10 nonsurgical specialists participate, whereas two out of three surgical specialists participate.

Geographic Participation

Areas of greatest participation by physicians tend to appear with highest impaction of recipients and major medical centers with the exception of east Mississippi and the Gulf Coast.

BREAKFAST OF CENTENARIANS

The press was interviewing the old man who had just celebrated his 100th birthday. He rocked back and forth on the porch and puffed a corncob pipe.

"To what do you attribute your marvelous vitality?"

"I don't rightly know yet," he said as he blew smoke lazily. "I'm dickering with two breakfast food companies right now."

Community Mental Health Centers

MARY ALICE LEE, M.D.
Jackson, Mississippi

I BECAME INTERESTED in the community approach to mental illness gradually as I became aware of the situation:

(1) In Mississippi there are 2.4 psychiatrists per 100,000 population while Washington, D. C. has 37 and New York State has 17 per 100,000;

(2) In state mental hospitals there are 215 patients per doctor while Iowa has 24 patients per doctor;

(3) The average daily expenditure per resident patient in state hospitals as late as 1967 was $3.34 per day and now is up to $5.00 per day. Mississippi's expenditure was $3.34 as compared to Alaska's $26.48;

(4) Mississippi spends $.10 per person per year for community mental health programs while New York spends $2.79 per person; and

(5) The state provides 23 man hours in outpatient clinics per week per 100,000 population. The U. S. average man hours per 100,000 population is 221 and in Washington the number is 758.

The Director of the National Association for Mental Health says that in 13 of the 15 indices used by the American Psychiatric Association and the National Association of Mental Health to measure mental health programs that in 13 of the 15, Mississippi ranked either 48th, 49th or 50th.

The Community Mental Health Movement was born in February 1963 when President John F. Kennedy delivered a message to Congress on mental illness and mental retardation. He proposed some sweeping changes in providing mental health services including the establishment of comprehensive community mental health centers. He said, "Merely pouring federal funds into a continuation of the outmoded type of institutional care which is now provided would make little difference. We need a new type of health facility, one which will return mental health care to the main stream of American medicine and at the same time upgrade mental health services."

There were serious deficiencies in Mississippi mental health programs before the Community Mental Health Centers Act of 1963. Since then, plans have been made for 16 regional mental health centers in the state. Two centers have been opened and two others are under construction, according to the authoress. When completed, these plans will provide services for 34 counties and 1.25 million Mississippians.

He had called for a bold new approach. Congress acted on the president's recommendations by enacting the Community Mental Health Centers Act of 1963 which provided matching funds for construction of community mental health centers.

In 1965 the act was amended to include staffing grants for new services provided through these centers. A new system for the delivery of mental health services was created and a new era in American psychiatry had begun. The 1960's would see almost 400 mental health centers funded at a cost of $900 million in federal and local

Presented before the Section on Preventive Medicine, 102nd Annual Session, May 11-14, 1970 at Biloxi.

funds. The goal was set at 500 centers in 1970 and 2,000 centers by 1980.

Let us briefly review the events which preceded the decade of the 60's to gain some insight into the necessity for recommending such a radical program. For more than 150 years, mental health services had been available in the United States. At first, services were to be found only in small private hospitals. In 1841 a school teacher in Boston named Dorothea Dix began a crusade for the mentally ill. She was directly responsible for establishing or enlarging public mental hospitals in 20 states. The states, however, failed to provide adequate budgets as the hospitals grew larger and larger.

Public attention became focused on the extent of mental illness during World War II when it was discovered that a high percentage of rejections from the armed services was for mental or emotional reasons. In addition, the casualties of war included thousands of persons with a psychiatric diagnosis and for the first time brief on-the-spot psychotherapy.

NIMH ESTABLISHED

In 1946 the National Institute of Mental Health was established by Congress as a part of the U. S. Public Health Service. It was given the responsibility for providing national leadership in mental health and for administering training programs, conducting research and assisting communities in providing mental health services.

In 1955, Congress passed the National Mental Health Study Act which authorized a study of mental health needs and resources in the communities. The Joint Commission of Mental Illness and Health was an organization composed of 36 volunteer and professional organizations which conducted a five year study. The report to Congress and the President was titled, "Action for Mental Health." It contained numerous recommendations to deal with inadequacies in mental health care. A major one was that public mental hospitals were not able to meet the needs of the American people because they were located at great distances from those they served and because they were grossly under-staffed, overcrowded and sub-standard. Hospital stays were noted to be prolonged because of these conditions.

Soon after this report, Congress appropriated money for the National Institute for Mental Health to assist the states with comprehensive mental health planning. An intensive study was carried out between 1963 and 1965. About 30,000 citizens participated in the planning which led to widespread community organizations.

In Mississippi this study produced the Mississippi plan for services to be provided in 16 different mental health-mental retardation regions. The 1966 Mississippi Legislature created the Mississippi Interagency Commission and made it responsible for administering the funds for construction and staffing of mental health centers.

The Interagency Commission is composed of five men. They are the state health officer, the state superintendent of education, the state welfare commissioner, executive secretary and director of institutions of higher learning and executive secretary of the mental institutions board.

EXTENT OF PROBLEM

Why was all this necessary? What was the extent of the problem to be faced? In 1950 the population of the public mental hospitals was 513,000. By 1955 it was 559,000. Some hospitals had between 10,000 and 15,000 patients. Had that rate continued, the 800,000 mark would have been reached by 1973. The psychoactive drugs have made it possible for thousands of patients to be treated and maintained outside of the hospitals. Today there are 426,000 patients in the public mental hospitals. It is predicted that by 1973 there will be 186,000 resident mental patients. More than 600,000 people will be living and working in a community rather than existing in a state hospital.

Mental illness is still one of the nation's most serious health problems. Even today nearly one-half of all hospital beds in this country are occupied by the mentally ill. Their affliction costs nearly $20 billion a year in treatment and decreased productivity.

PERCENTAGE AFFECTED

One person in every 10 and one family in every four is afflicted with mental problems. Three per cent of the population is mentally retarded and 3 per cent of the population is alcoholic. At least 2 per cent of all school children need psychiatric help of some sort and only about 5 per cent of these are able to obtain the psychiatric help they require. Mental health services for the poor do not exist in many communities and, indeed, are available to the affluent only with great effort.

In 1960 there was a total of 44,000 psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses. In 1966 this number had increased to 64,000 and the 1970 figures were projected at 87,000 including 20,000 psychiatrists. It has been said that all the mental health professionals in the United States would not be able to treat the known mental patients in the state of California on a one to one basis.

The need was apparent and an attempt to solve the problem had begun. The criteria for eligibility for the centers required that care must be comprehensive. It must be readily accessible and available to all people within the geographic area designated as the catchment area. Each center must serve between 75,000 and 200,000 persons and must be available to all regardless of income level. The center programs must be designed to evaluate, diagnose, treat and rehabilitate. There must be continuity of care from precare to aftercare. The program must also include preventive measures, particularly consultation and education for community care-givers.

Each center must have a minimum of five service elements. These are an inpatient unit, an outpatient clinic, 24-hour emergency service, partial hospitalization and a consultation and education program. Five additional services may be included but not required. They are special diagnostic services, rehabilitative services, precare and aftercare, training programs, and research. It is my understanding that the Mississippi Interagency Commission has made aftercare an essential 6th element of services in the Mississippi centers.

CONTINUITY OF CARE

A mental health center may be under one roof or several as long as there is continuity of care. The patients, staff and information must move freely between various services.

The construction funds are available in the same way as the Hill-Burton funds. They are allocated on the basis of population and need with each state receiving a specific allotment. The state plan establishes a priority for the regions within the state. For Mississippi the funds are on the basis of two federal dollars and one local matching dollar. The 1966 Mississippi Legislature provided a means of supplying the local matching funds. The Boards of Supervisors were given the authority to appoint a commissioner who would join with the commissioners from the other counties in the catchment area to form a Regional Mental Health Commission. The Boards of Supervisors could also levy a 2 mill tax in support of mental health and mental retardation programs.

The staffing money was originally made available on a matching basis beginning at 75 per cent of professional staff salaries and decreasing stepwise each year to 60 per cent, 45 per cent and 30 per cent and ending in 51 months. In March 1970, however, Congress extended the staffing period to eight years and made it possible for poverty areas to obtain grants beginning at 90 per cent. These staffing funds are not allocated to the states and are competitive on a nationwide basis. Priority is given to model cities and to those centers who have received construction funds. Successful applicants include public general hospitals, public mental hospitals, private mental hospitals, university hospitals associated with medical schools, children's clinics, residential facilities. But the most common applicant is the voluntary general hospital and the most frequent combination is the voluntary general hospital and an outpatient psychiatric community clinic.

INDIVIDUAL PLANNING

No two centers are identical in organizational structure, the type of service or programs offered or source of funding. The plan for each center must be based on the needs and resources of that particular catchment area. It is easy to see how the program of a center serving hundreds of square miles in a sparsely populated western state would differ from that covering a few blocks in one of our larger cities.

The average cost of construction is $1.2 million, a figure which is two years old. The average center serves 165,000 people and has a staff of four psychiatrists, three clinical psychologists, seven social workers, eight professional nurses, three licensed practical nurses, six rehabilitation staff members and 11 psychiatric aides, making a total of 42 people.

Most centers deal with the immediate crisis and then continue to follow the patient and his family for an average of six visits while the patient remains at home with his family. Some centers have a few beds in the emergency room where patients may stay for a day or two without admission to the hospital.

TREATMENT REQUIREMENTS

The average length of stay as an inpatient is from 14 to 21 days. Ten per cent to 20 per cent of the patients require transferral to the long term facility such as a mental hospital. Eighty per cent to 90 per cent can be treated locally in general hospitals and then followed in the day hospital or in the outpatient clinic.

Partial hospitalization is a relatively new concept in this country although it has been used successfully many years in other countries. Partial hospitalization allows the patient to live at home while receiving treatment for all or part of the day. He may continue to function at his job or attend school and remain with his family and friends. It is, of course, even more important to work with the family in these cases in order to assist the family in coping with the problems.

The consultation and education services are the preventive part of the center's program. Many community agencies and community care-givers make frequent contacts with individuals who are under stress. This group includes physicians, nurses, public health workers, lawyers, teachers, court and probation officers, police and welfare workers. All of these should be able to identify mental illness and provide assistance when they encounter it. By providing in-service training and consultation to these groups, many more people can be reached and assisted with their problems.

The geographic location and administrative structure of each center largely determines its clientele and its program. In rural areas and in small communities, centers usually serve the entire population because they are often the only source of psychiatric help for many miles. Public hospitals in larger cities tend to serve the lower socio-economic groups while those who can pay seek private care. Centers in voluntary hospitals admit both private and indigent patients.

SATELLITE CENTERS

In states where the population is sparse and it may be 50 miles or more from the center to the edge of the catchment area, satellite centers are established in some communities. A mental health worker assigned to the satellite may provide follow-up services for ex-hospitalized patients, give consultation to community professionals and arrange for clinic visits with the center staff who would come on a regularly scheduled basis.

Mental Health Centers are located in all of the 50 states and in Puerto Rico. California has the most with 36 having been funded and 23 already in operation. Pennsylvania has 29 funded and 14 operating. Kentucky, however, seems to have the most coverage serving somewhere around 85 per cent of its population through 26 funded mental health centers, at least 16 of which are in operation.

Many of the centers have been in operation long enough to begin to have problems. There are two major ones. The first is the provision of continuing operating funds from local sources. The second problem centers around the authority for planning programs. Many of the centers have been established with programs based on recommendations from an advisory council made up of consumers of the service. The demands of various groups and friction between community agencies have interfered seriously with some of the center programs and make it impossible to operate on a sound financial basis. Indeed, several centers are on the verge of closing and many clinical directors have resigned.

To date in this program almost 400 centers have been funded, about one-half of which have begun services. These 400 centers will provide readily available services to 65,000,000 Americans. It is known in these centers that 2 per cent of the population will present for psychiatric help in a given calendar year.

MISSISSIPPI CENTERS

Let us take a look at centers planned for Mississippi. The 16 regions in Mississippi have been based on the population requirements of 75,000 to 200,000 and on traditional county alignment. Each region contains a medical and trade center large enough to have a coordinated program. Mississippi's first center opened in Tupelo on Jan. 1, 1968 serving seven counties. The second center opened Jan. 1, 1970, in Oxford, also serving seven counties. Two others are under construction, one at St. Dominic-Jackson Memorial Hospital in Jackson and the other in Greenville. Two staffing grants have been approved but not yet funded. These are the mental health center in Clarksdale and the Coastal Community Mental Health Center in Gulfport. A construction application for Meridian is pending approval. Ten of the 16 regions have commissioners and seven regions have completed plans. These plans will provide services covering 34 counties and 1.25 million Mississippians.

What is the physician's role? The federal community mental health center program places considerable emphasis on the contributions from non-psychiatric physicians. The federal regulations specifically call for general physicians to be included in the program. This enables the physician to continue following his patient who is receiving care in the center. This plan assures continuity of care. The general practitioner is already doing the major part of treating emotional disturbances and this is a plan whereby he might obtain psychiatric consultation.

THE PHYSICIAN'S ROLE

The physician is in the best position to know the needs of his particular locale and, therefore, is a valuable member of the planning team. The physician should be aware of the extent and nature of mental illness. He should know the signs and symptoms and the local resources and be willing to accept a returning patient. The initiative for these programs should be local and the physician should take a position of leadership in formulating plans.

What has been said thus far has been based on facts, materials presented in the literature and my personal contacts with state, regional and national leaders. It does not necessarily represent my

opinion and that of my employers. I would, however, like to express some of my personal opinions about these programs. In the first place, our state administrative structure is such that there are three major agencies involved in the mental health business. These are the state hospital system, the Mississippi Interagency Commission and the Mississippi State Board of Health. Without any personal criticism intended, I would like to point out that it is difficult to coordinate programs of three agencies so that continuity of care is assured or that planning is accomplished without serious gaps or duplications. It is my personal opinion, therefore, that we need some major changes in the over-all administrative structure of Mississippi mental health programs.

So far as the centers are concerned, I have some reservations. I do not wish to detract from the enthusiasm here, but I wonder if we are not overly ambitious in planning for 16 centers in the foreseeable future. The first question is one of money.

COST CONSIDERATIONS

If the cost of construction is around $1.5 million for an average center, then we are talking about $24 million of construction. If the budget is, for the average center, about $1 million per year, then we are talking about $16 million annual operating cost. Let me remind you that we are presently spending about $15 million per year for mental illness. The federal government has promised funds but has insisted on planning the program so that a major part of it is not reimbursable, that is for the indigent care and the consultation and education program. At some point in time the federal government will discontinue its support and if the program is to be continued, it must have local support funds. Already we see the federal government withdrawing.

Two centers in Mississippi are approved but not funded and Dr. Stan Yolles, Director of National Institute of Mental Health, states that there are more applications than funds. Locally, we see counties providing millage for the mental health program but subtracting it from the public health budget. I am in favor of psychiatric care but not at the expense of maternal and infant care or communicable disease control. It seems to me that President Kennedy's Camelot may succumb to an awesome fact that budget is the program.

My second concern is one of manpower. If we are thinking of 16 centers and if these centers are average, then we are thinking of about 64 psychiatrists when there are now only 45 psychiatrists in the state and we are talking about 48 clinical psychologists. Now there are only 14 in the state, and similar shortages exist for social workers and nurses. Sixteen centers with 42 staff members in each is a total of 672 mental health professionals. If each center had only one psychiatrist, I do not know how we could attract 16 psychiatrists to this state with the lowest per capita income in the nation. Sixteen psychiatrists are all that our current residency program will produce in four years. The only alternative would be to import them which I personally feel leaves a lot to be desired.

GOVERNMENT PARTICIPATION

My 3rd and last concern is this: Although I do not wish to draw any conclusions, I must point out that for the first time the federal government is in the business of not only preventing illness but also of treating illness for all income levels and they are doing so in a big way. The original legislation in 1965 called for staffing assistance for 51 months. In March 1970, Public Law 91-211 increased the percentage and extended the period to eight years. Congress also authorized another $622 million for the program through the fiscal year 1973. Already the literature contains such statements as "We have learned that these centers can become human service centers as well as facilities to treat the mentally ill," according to Secretary of HEW Wilbur Cohen in Nov., 1968. Dr. Stan Yolles, Director of National Institute of Mental Health, has said that the community mental health centers "have become prototypes of the delivery of all health services."

Certainly mental illness is a public health problem. It is the nation's number one health problem. All of us would agree that some level of government must provide prevention and treatment for the indigent.

It seems to me that a cooperative working relationship between the mental health centers and private physicians is in order and should be given some priority in planning.

SUMMARY

In summary, let us take a brief review of the decade of the 60's and a look forward into the 70's. The 60's brought the realization of the extent of the mental health problem and produced programs with a public health philosophy. It produced a new breed of psychiatrists who have become more involved in the community. It brought the use of paramedical personnel and provided training programs for them and new terms were introduced such as mental health technicians and mental health workers.

This decade saw widespread use of psychotropic drugs with a decrease in resident patient population of our public mental hospitals. There was an increase in admission rates with shorter hospital stays. There was increased demand for services as a result of better knowledge of illness and of resources.

The 60's brought emphasis on crisis intervention and Millieu therapy, on continuity of care, comprehensive services and on community participation. This decade also brought unprecedented federal control, a bipartisan program with an annual budget of $362 million, a figure which is four times the 1960 budget. But more people had received better care and there was a brighter outlook for obtaining mental health services for the average American than at any time in the past.

A look into the 70's reveals the following projected programs: (1) accelerated research, (2) increased efforts to train manpower, (3) establishment of more Comprehensive Mental Health Centers, (4) inclusion of protection against mental illness in health insurance, (5) expansion of mental health services to children and youth, (6) increased mental health care and education of the poor, (7) increased efforts in family planning, (8) evaluation of state laws concerning treatment of the mentally ill, (9) stronger programs in areas of delinquency, drug addiction and alcoholism, and (10) promotion of mental health on a broad basis through better housing, education and welfare, job training and other environmental health programs.

Let me close by issuing another plea for you as physicians to become interested and involved in the planning for mental health services in your area. The mental health movement has caught fire and has gained momentum. If you are not present, I fear that the planning will go on without you and it will be done mostly by laymen and non-medical mental health professionals. Your skill and knowledge is invaluable in planning and implementing these programs. Your presence is needed and urged. ★★★

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LITERATURE LITURGY

Seldom does the medical literature yield up gems as liberally as in papers describing drug research. Consider these, along with tongue-in-cheek "translations:"

"The manner in which the response is mitigated offers challenging investigative opportunities."

Translation: We don't know how it works.

"A growing body of scientific opinion tends to support these findings."

Translation: Another investigator has published a paper which doesn't entirely disagree with this one.

"A search of the literature discloses a paucity of data in this field."

Translation: There was nothing about it in last week's JAMA.

"We wish to thank ABC Laboratories for their scientific commitment to this research for a better agent."

Translation: They paid us.

Radiologic Seminar CIII
Ischemic Necrosis of the Capital Femoral Epiphysis

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EPIPHYSEAL ISCHEMIC necrosis is a condition known variously as osteochondritis deformans juvenilis, the osteochondroses—epiphyseal aseptic necrosis, or epiphyseal osteochondritis. This same condition is often designated by an eponysm depending upon location. When the process involves the capital femoral epiphysis it is known as Legg-Calvé-Perthes' disease, Perthes' disease, or coxa plana. The same process in other epiphyses is known by various eponyms, i.e. Osgood-Schlatter disease (tibial tubercle), Kohler's disease (tarsal navicular), Freiberg's disease (second metatarsal head), and Scheuermann's disease (vertebral bodies).

Ischemic necrosis of the femoral head is the most important member of this group both from the standpoint of incidence and morbidity.[1]

The underlying etiology of this process is almost certainly an interference with the blood supply of the epiphysis which in one sense of the word results in a bone infarct. The interference with the blood supply may be from emboli, thrombi, tearing of blood vessels from trauma, infection or endocrine disturbances, but the common denominator is the same.

Ischemic necrosis of the capital femoral epiphysis affects children between the ages of three and 12 with the peak incidence at six to eight. It favors males in a ratio of 4 or 5 to 1. Approximately 10 per cent of the cases are bilateral. A typical case probably never starts after age 12 for at this age there is some communication between the blood vessels of the epiphysis and metaphysis. The disease is rare in Negro children, and it has been said that this is due to the greater blood supply through the ligamentum teres at the critical age in Negro children than in white children.[2]

The most common symptoms are limp and regional pain. Frequently, pain is referred to the medial aspect of the ipsilateral knee. The symptoms may be insidious in onset or sudden. The pain may be referred to the inner thigh or the groin following the distribution of the obturator nerve. It is relieved by rest and worsened by activity. Motion is frequently limited. Fever has been present at the onset in a few cases. Symptoms may be present for only a short while in some cases with radiological evidence of advanced destruction. Conversely, other patients have shown only slight radiological changes after limping for three to six months.

The disease process has been described as having four phases. The first phase lasts two weeks to two months. Only soft tissue changes occur at this time. There is swelling and a low-grade inflammatory reaction in the joint synovia and capsule.

The second phase is characterized by necrosis of the osseous nucleus and enchondral plate. This phase usually lasts six to 18 months.

Replacement of the dead tissue by fibrous tissue and eventually by new bone and cartilage takes place during the third phase. The duration of this phase is from one year to three and one-half years.

The residual changes which persist after healing constitute the fourth phase. The changes include a flattened femoral head, a shortened and thickened neck, and an enlarged acetabulum.

The radiographic changes in ischemic necrosis of the capital femoral epiphysis depend upon the physiological and anatomical alterations.

During the first phase of the disease, radiographic changes are minimal. Synovial thickening and fluid within the joint may produce a bulging of the joint capsule. The capsule may be visualized by virtue of contiguous radiolucent fat. The earliest visualized bony abnormality may be demonstration of a lucent crescent antereolaterally that parallels the subchondral surface of the epiphysis. A little later, areas of increased density may be seen within the epiphysis. The areas

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Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Greenwood Leflore Hospital.



Figure 1. AP view. (Left) Note slight flattening superiorly and laterally. Crescent area of increased density is seen in subchondral area superiorly.



Figure 2. Frog leg lateral view. (Right) Moderate flattening and compression is seen superiorly and laterally. Some irregularity of subchondral area is seen. Compared to left the right epiphyseal line is widened and the cartilage space is widened compared to left. Slightly increased density of the right epiphysis is seen.

of increased density represent infarcted areas which cannot demineralize. The surrounding more lucent areas are a result of hyperemia and/or disuse osteoporosis secondary to pain. The epiphyseal line widens and may show cystic changes because its blood supply is lost also. The resulting ischemia causes swelling of the cartilage cells.

During the second stage, granulation tissue invades the necrotic epiphyseal center and weakens it. This results in flattening and fragmentation of the epiphyseal center. There is an increase in opacity of the epiphysis apparently from collapse and apposition of its fragments.[1]

In the third stage healing begins, new bone is formed, and the borders of the epiphysis again become regular and intact. In this stage the femoral neck becomes shortened and widened. The acetabulum enlarges to accommodate the flattened and broadened femoral head.

Radiographically, the fourth phase is represented by the final deformity of the hip joint.

The clinical course of the disease and the ultimate deformity depend upon the age of onset, the number of vessels occluded, and the amount of usage of the injured extremity. In general, the damage is greater the younger the patient. The most serious complication is the development of a crippling traumatic osteoarthritis during the third and fourth decades of life, frequently after the patient has been asymptomatic for 10 years or longer. This is apparently due to the chronic bad fit of the enlarged femoral head into the acetabulum.[3]

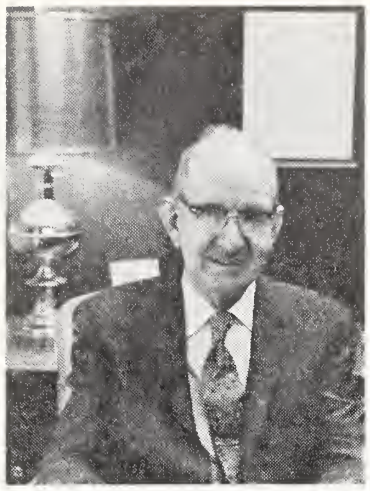
SUMMARY

Ischemic necrosis of the capital femoral epiphysis is almost certainly due to an interference with the blood supply of the epiphysis. It affects children of ages three to 12 and predominantly males in a ratio of 4 or 5 to 1. Radiographic findings depend upon anatomical and physiological changes. Traumatic osteoarthritis is a serious complication usually developing in the third or fourth decade of life. ★★★

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The President Speaking

'Toward Peer Review'

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Lexington, Mississippi

PEER REVIEW HAS BEEN discussed many times in detail through our societies and in our JOURNAL. It was the most discussed and debated issue before the House of Delegates at our recent Boston meeting. Something more can now be added as PSRO is more closely defined. We can appreciate how our peer review committee can fit into the national scheme.

Senator Talmadge, the vice chairman of the Senate Finance Committee, made it unmistakably clear that the government demanded an accountable source for the cost as well as the quality and quantity of health care that it is buying for $15 billion. He declared that his committee is a friend of medicine, but that we must assume this responsibility as there are other applicants for the task. We must make policing of health care an effective means of lowering the cost. We must decide between necessary and unnecessary services and the difference in cost between in- and outpatient utilization, as well as the cost of treatment in various kinds of facilities.

All of these things I am sure our association is capable of doing with its present setup. Most of the objectionable features of the original Bennett amendment have been revised. Regional norms, such as our committee has almost completed, will replace national norms, but to make an accommodation with those in HEW who insist we are dishonest. There is the possibility of the Secretary excluding physicians from the program and a medical society as such can not be a peer review panel although this panel can be organized and set up by a society. This was included because it would preclude non-members of organized medicine from its panels. Some members of the finance committee were impressed by organizations which asserted that the AMA had a bare majority of all physicians in their ranks. We, of course, have 91 per cent of all physicians who actually practice medicine. The state or regional panel can accept findings from any effective peer review organization, regardless of its make-up. The power of preadmission review was left in the hands of local panels, which upon retrospective investigation, believe this to be necessary, but this is only possible at the local level and some malpractice protection was supposed to reside in this act both for review board members and also the provider of services.

A matter of great concern was resolved by the decree of this act which states that "No PSRO shall utilize the services of an individual who is not a physician to make final determination with respect to professional conduct of any physician in the exercise of his profession." This 53 page amendment will be subject to HEW's interpretation for the details of its implementation. This will be like awaiting the dropping of the other shoe.

(Turn to page 25)

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 1

JANUARY 1971

EDITORIALS

Decade of Decision: The Economy and NHI

There are more things in heaven and earth, Horatio,
Than are dreamt of in your philosophy.

—Hamlet, Prince of Denmark
Act I, Scene V

I

HAMLET, having talked to the ghost of his father, was telling his university chum about things supernatural. But he may just as well have been describing the crazyquilt state of the nation as the first year of the 1970's ends. Some might go so far as to assert that society is mad, that the economy is mad, and that the Congress is everything Will Rogers said it was.

Not the least among these grave concerns is the state of medical care delivery, bending under the weight of government finance mechanisms, paperwork, expanded purchasing bases, and all the rest of the programmed innovations. Now before us are no less than five serious proposals for a national health insurance plan, every one of which is as real as rain.

The lame duck 91st Congress wrote four NHI proposals into its last chapter as it left much unfinished business and finished some which the country may be better off without. Before the solons in the dying hours of the session were NHI bills by Kennedy, Griffiths, Javits, and AMA. Now comes the American Hospital Association's Ameriplan, still another far-reaching proposal to weave together a universal medical care financing mechanism of corporations, government, and taxes.

Nobody can doubt that the winds of change are blowing, but the socioeconomic meteorologists would be hard put to explain gale winds from five directions at the same time.

II

The widest perspective, reduced to the lowest common denominator of simple understanding, is difficult enough to perceive on exactly why the nation seems to be rushing head on toward universal health care financing. The lessons of Medicare and Medicaid have been learned poorly. The number one federal medical executive, Dr. Roger O. Egeberg, Assistant Secretary of HEW, has freely conceded that we can hardly be ready for national health insurance when we haven't found out how to handle these two programs.

The thrust of this school of thought is directed toward the potentially disastrous impact on the *supply and availability* of medical care which new, yet undefined financing mechanisms would exert. Nobody is going to be denied care in this day and age where public and private third parties are picking up half the $70 billion annual tab, nor is medical care about to be rationed. But the stockbrokers will tell us that a runaway market becomes disorderly, making rational transactions difficult.

Regrettably, our lowest common denominator to the medical care equation is preceded by a government dollarmark. We can no longer count on the political right to hold the reins of restraint. John S. Knight, the distinguished newspaper publisher, writes that "our conservatives who preach economy and efficiency in government are often the biggest spenders of all."

Mr. Knight says that "to a man, the conservatives in Congress supported the Vietnam War." He charges that "even our President, with his Family Assistance Program, would add an estimated 12 million persons to the welfare rolls at a beginning additional cost of $5 billion a year."

Now, this would more than double the cost of Medicaid to the federal government and the states. Astonishingly, here is a simple plan to zoom government spending for health care without writing a line of new medical legislation. If the squeeze on the supply is tight now, the Nixon FAP—sure to be a major social welfare issue in the 92nd Congress—is a guaranteed crunch on care delivery.

Continued expansion of the care purchasing base with government writing the checks is no more way to improve delivery than killing the fabled goose to get all the golden eggs at once. A little rational thinking and self-appraisal on the part of government is instantly in order. Failing this, the consequences are almost certain to be distasteful to disastrous.

III

Putting aside for the moment the hazards clearly implicit in NHI and the delivery of care, look at the economic madness which can only be exacerbated by such an enactment. Mr. Knight sets the stage: "Years of costly involvement in a futile war, huge grants and easy loans to other countries, a burgeoning bureaucracy brought on by proliferation of Lyndon Johnson's Great Society programs, no real effort to curb inflation when the trend was evident, outrageously inflationary wage settlements followed by instant price hikes, and a selfish society unwilling to make the slightest sacrifice have all invited and contributed to the mess we are in."

The national trend scoreboard for 1970 offers little reason for a happy new year. Our Gross National Product, all the goods and services we produce in a year, was $958 billion, up 4.5 per cent over 1969, but the federal debt rose 5.2 per cent. Corporate profits were down nearly 12 per cent, and they are the lifeblood of the economy. Industrial production was down 4.5 per cent to $166 billion. Employment actually rose a minute 0.3 per cent to 78.4 million, but the population rose by 2.1 million.

Disposable personal income, the unctuous way we say what's left after the tax collector swings the axe, rose 8.2 per cent to $693 billion, but consumer prices scored increases of about 10 per cent. And if you have been to the supermarket lately, it makes you wonder why farm income was down by half a billion dollars when many food items were up as much as 30 per cent.

Now, seriously, does this sound like an economy ready for an *additional* tax expenditure of as much as $77 billion a year for national health insurance?

Anybody who can understand the facts and still answer in the affirmative ought to slip into his toga and go pick up his free bread and circus tickets.

IV

Quite obviously, there is no easy way out of this insane dilemma. Even worse, there may be no way out at all. But if this pessimistic attitude were universally adopted, then we may be certain that the entire mess would blow up in our face.



"I drink for medical reasons—my mother-in-law is a nurse!"

American medicine is one of the few institutions which makes progress in spite of adversity. Each hour, literally, it has more to offer. Through medical organization at the local, state, and national levels, physicians are giving generously in time and substance to deliver more and better care. Private financing, care foundations, peer review, delivery programs, expansion of allied professional fields, manpower plans, and a host of innovations make up a list spanning an area of remarkable endeavor.

The new year will not be easy or devoid of more trials and tribulations. More than ever before, the voice of the physician must be heard, and the will and wishes of his medical association must be widely communicated. This is a decade of decision—not just for medical care delivery but for the nation as well. And all of these American Horatios had better believe that there are more things in the 1971 state of the nation than are dreamt of in their wildest philosophy.—R.B.K.

Give a Day, Doctor! You're Needed

Doctor, your state medical association needs your personal and professional services for one day in the next 90.

The new and expanded legislative program of the association has as its first goal putting every member in *weekly* communication with his senator and representative during the 1971 Regular Session of the Mississippi Legislature. The program, conceived by Dr. C. D. Taylor, Jr., of Pass Christian, chairman of the Council on Legislation and former chairman of the Board of Trustees, is dubbed "Give a Day for MSMA."

We need little reminder that the going was rough when the solons were in session last year. A succession of measures damaging to medicine flowed into the hoppers of both houses on Capitol Hill at Jackson. Day-to-day contact with legislators by a few association leaders and staff was not enough.

Senators and representatives frankly said that "we have never heard a word from the physicians at home, so how are we to know that they are for or against a given measure?"

The members of the legislature make it clear that one call or one letter written to exhort them to vote against chiropractic licensure or for better autopsy laws simply isn't enough. They earnestly ask for *continuing communication* with the medical profession. And the association is doing its part, also with your sanction and blessing. Part of the increased funds provided for the legislative program go to produce your new "Mississippi Medical Legislative Report," the weekly newsletter-type, quick reading bulletin which will be on your desk by first class mail each week not later than Friday morning.

But back to that day your profession needs from you. Of course, one of the most effective days of service is that of Doctor of the Day in the association's Emergency Medical Care Unit at the Capitol. The EMCU will open Jan. 5 and keep regular hours on each legislative day of the 1971 session. Mavis Barlow, R.N., who served so well for the past two years, will again be on the job.

The DOD has the rare opportunity for face-to-face contact with the legislature in session in addition to the service aspect of the program. And it is not an empty gesture, either, because there have been serious medical emergencies on Capitol Hill along with the URI's, headaches, and minor miseries.

But only 4 or 5 per cent of the membership can be DOD's, leaving the vast majority to serve in other capacities. Dr. Taylor reminds us that we will need witnesses to testify on legislative matter before committees of the legislature. A day of contact visits to Jackson can be valuable, too. The day may involve a speech to a Rotary, Kiwanis, Lions, or other service club. A physician could be called upon to make a trip to a nearby local medical society meeting and share his knowledge on a particular legislative matter with fellow physicians.

The "Give-a-Day" program offers limitless opportunity to make the physician's influence felt and to benefit from his leadership. It does *not* involve Saturdays and Sundays, although many, if not most, will make hometown legislative contacts on particular issues during weekends.

The association, in behalf of all Mississippi physicians, has a positive legislative program for 1971. It is *your* program, built on *your* resolutions, *your* professional needs, *your* council and committee work, and *your* action in *your* House of Delegates. In the final analysis, only *you*—along with your 1,450 colleagues in the association—can make it real.

And on the "Give-a-Day" program, let's leave it this way: Please call us, and we'll call you!—R.B.K.

Pot for Profit and Legal, Too

Ordinarily, the JOURNAL couldn't be less interested in goings on at the 55th Annual Convention of Federal Wholesale Druggists Association as reported recently in the *American Druggist,* an industry trade journal. But the speech of one Mr. Seth Harris of Cleveland, O., the then-president of FWDA, is more than a matter of passing, casual interest.

Mr. Harris must be one of the now generation supersalesmen in his industry. He also has some unbelievable ideas, if the report of his presidential address is to be believed. Not only did it catch our eye; it also turned our stomach. Said Mr. Harris to his fellow drug wholesalers:

"As we look for new and profitable ventures, it is entirely possible that marijuana will become legalized, and the distributorship rights will become an avenue for countless dollars in profit."

You may wish to re-read the previous paragraph, because no thinking individual can possibly accept the assertion as a serious business recommendation. Were this to come true, Jay Gould's cornering the gold market would ring through the pages of history as an act of charity. The thought that the friendly pharmacy might become the local pot parlor is a little too repugnant, and there simply aren't enough four letter or other words to describe the proposal to traffic in the minds and bodies of human beings in pot-for-profit merchandising.

It is perfectly reasonable to believe that the vast, vast majority of drug wholesalers feel the same way as we do over Mr. Harris' idea for "an avenue for countless dollars in profit." And the pharmacists, as ethical, respected members of the health care team, would surely have no part of this reprehensible proposal. Ugh!—R.B.K.

Well Done and Good Luck, Jay

The new general counsel and director of the Office of Legal Affairs of the American Hospital Association is Jay H. Hedgepeth, a Jacksonian for 16 years and a native of Brookhaven. The noted young attorney has distinguished himself in the field of hospital law, and for a decade and a half, he has served as legal counsel to the Mississippi Hospital Association.

Going on to newer, bigger, and greener fields is an expected step for the growing and qualified. Mr. Hedgepeth received his B.A. degree from the University of Mississippi in 1951 and his LL.B. from the Ole Miss Law School in 1954. He joined a prominent Jackson law firm that year and has since become a partner.

His work with the state hospital association brought him in contact with medical leaders of the state. Frequently, he was a key figure in health and medical legislation, and he was a respected consultant to many a senator and representative in the legislature. The Mississippi statute books contain many laws which he authored and to which he made notable contributions.

Mr. Hedgepeth published the *Mississippi Hospital Law Manual* in 1968, and his practice also found him as legal adviser to a number of mid-state hospitals. His new duties with AHA will take him to Chicago, the hub of health and medical national organization activities.

We note Mr. Hedgepeth's leaving the state as the loss of a leader, a friend of Mississippi medicine, and as a prime example of that trite but true fact that one of our principal industries



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"But you told me to put the specimen on the table."

is exporting bright, able individuals to other states. He goes with the good wishes of the Mississippi State Medical Association and with the recognition that his leadership and contributions in the future will benefit 49 other states as well as our own. We congratulate the American Hospital Association and say, "Good luck, Jay!"—R.B.K.

IRS Will Get Payment Reports

Revenue Ruling 69-595 goes into effect Jan. 1, and it promises to increase the sea of paperwork associated with the financing of health care in the United States.

Under its rule-making power based in statute, the Internal Revenue Service will henceforth require anybody who pays a health care provider $600 or more in one year to report the payment, using a new form, IRS 1099C, for this purpose.

Reporting payments from which no federal income taxes have been withheld is nothing new. For 16 years, the Internal Revenue Code of 1954 has provided that any corporate or partnership entity which pays $600 or more in one tax year to any individual without withholding income taxes must report the payment. Generally, this has been done in cases of contract labor, certain professional services, and in other instances where the payee's compensation was not under withholding tax.

The new ruling will be nonretroactive on health care payments except for Medicare and Medicaid. This means simply that payments made *after* Jan. 1, 1971, must be reported. For the two massive health programs, it applies to payments made during 1970. The new informational return, the 1099C, must be prepared and submitted by the payor.

During the present tax (calendar) year, there will be joint IRS-insurance industry conferences on just how to retrieve and collate the information and which means of doing so will satisfy the IRS requirements. Historically, the insurance industry and Blue plans have not reported payments to physicians and other providers.

Medicine opposed the ruling, asking IRS to defer the edict until more discussion on it could be conducted. The problem is that physicians, dentists, and others frequently provide supplies, medications, devices, appliances, dentures, and the like, adding these costs in the overall charge. This full amount, when reported as a payment to the provider, distorts the tax picture.

There will be bugs and problems in the new reporting system, and care providers will be well-advised to maintain file copies of claims submitted where services and supplies provided are itemized. The matter is one to be discussed with personal auditors, the C.P.A.'s, who are best prepared to advise on the effect the new procedure will have on individual tax situations.—R.B.K.

PRESIDENT (Continued)

The amendment now carries a proviso that all nonassigned bills above $600 paid to individuals supposedly to satisfy doctors' bills must be reported to IRS as a possible check upon we dishonest physicians. Too, a catastrophic insurance feature under Social Security itself has an excellent chance to be included in some form of this act. Our PRO can easily be molded into any future demands. ★★★

POSTGRADUATE CALENDAR

MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Feb. 1-5, 1971

ELECTROCARDIOGRAPHY INTENSIVE COURSE

University Medical Center, Jackson

Feb. 1-5, 1971, beginning at 8 a.m.

Sponsored by The University of Mississippi School of Medicine postgraduate education committee, with the support of the Mississippi Postgraduate Institute in the Medical Sciences

Coordinator:

Thomas M. Blake, M.D., professor of medicine, The University of Mississippi School of Medicine

Offered for the second time this year, this one-week intensive course is structured for the physician who uses electrocardiography but who has had little formal instruction. Registrants will study disorders of cardiac mechanism, introventricular and atroventricular imbalance. They will participate in discussions, conferences, rounds, lectures and demonstrations. Registration is limited to a class of five

family physicians from the 40 currently enrolled in the Mississippi Regional Medical Program-funded Mississippi Postgraduate Institute in the Medical Sciences.

CIRCUIT COURSES

Southwest Circuit

McComb—Jan. 12—Session 2; Southwest Mississippi General Hospital, 7 p.m.
Natchez—Feb. 16—Session 2; Jefferson Davis Memorial Hospital, 7:30 p.m.
Session 2—Carcinoma of the Thyroid, Dr. Coupery Shands
Presentation and Diagnosis of Hypothyroidism and Hypoparathyroidism, Dr. Herbert Langford

Southern Circuit

Gulfport—Feb. 3—Session 2; Gulfport Memorial Hospital, 6:30 p.m.
Hattiesburg—Feb. 4—Session 2; Methodist Hospital, 6:30 p.m.
Session 2—Clinical Management of Pneumonias, Dr. Joe R. Norman
Current Trends in Diagnosis and Management of Hepatitis, Dr. Lidio Mora

Eastern Circuit

Columbus—Feb. 23—Session 2; The Downtowner Motor Inn, 6:30 p.m.
Session 2—Diagnosis and Management of Rheumatoid Arthritis, Dr. Thomas E. Wilson, III
Mechanisms of Anemia, Dr. Francis Morrison

FUTURE CALENDAR

Jan. 12, 1971
Circuit Course, McComb

Jan. 13
Seminar on Problems in the Newborn

Jan. 18-22
Cancer Chemotherapy Intensive Course

Feb. 1-5
Electrocardiography Intensive Course

Feb. 3
Circuit Course, Gulfport

Feb. 4
Circuit Course, Hattiesburg

Feb. 16
Circuit Course, Natchez

Feb. 18
Neurology Seminar

Feb. 23
Circuit Course, Columbus

March 1-5
Gastroenterology Intensive Course

March 3
Circuit Course, Bay St. Louis

March 4
Circuit Course, Hattiesburg

March 5
Renal Seminar

March 8-12
Nephrology Intensive Course
Cardiology Intensive Course

March 9
Circuit Course, Meridian

March 24-26
Cardiovascular Seminar

April 5-9
Pediatrics Intensive Course

April 6
Circuit Course, Meridian

April 13
Circuit Course, McComb

April 19-23
Radiology Intensive Course

April 20
Circuit Course, Natchez

April 27
Circuit Course, Columbus

May 3-6
Mississippi State Medical Association

May 11
Circuit Course, Meridian

PERSONALS

DEWITT T. ALLRED and Mrs. Allred of Collins recently celebrated their golden wedding anniversary with a reception given by their children.

RICHARD L. BLOUNT of Jackson announces the removal of his office to 882 Lakeland Drive. Dr. Blount limits his practice to ophthalmology.

JAMES E. BOOTH of Eupora has been re-elected president of the Clarke College Alumni Association.

HOLLIS BURROW of Greenville was a recent speaker at the Greenville Kiwanis Club. He spoke on the John Birch Society.

CECIL FRANKS and BROWN ROBERTSON of Tupelo announce the relocation of their office at 808 Garfield.

HANNELORE GILES of Hattiesburg, E. H. COLE of Richton, L. Z. BROADUS of Purvis, and FREDERICK E. TATUM of Hattiesburg were participants in the District 10 Heart Association program at the University of Southern Mississippi.

WALTER GUNN of Quitman has been named president of the Clarke County Heart Association. JAMES C. GRAHAM of Enterprise was elected medical representative.

PAUL L. HORN, JR. of Ocean Springs has been elected 1971 president of the Coast Counties Medical Society.

PATRICK H. LEHAN of Jackson and UMC was guest speaker at the District Three annual Heart Fund Dinner in Greenville. Dr. Lehan spoke on heart fund supported research in Mississippi.

A. H. LITTLE of Oxford has announced his retirement from the general practice of medicine.

ALICE MAIER, JULIUS BOSCO, and MATTHEW KULUZ, all of Pascagoula, discussed the growing controversy on abortions at the recent meeting of the Pas-Point Ministers Association.

W. T. MAYER of McComb has been elected chief of staff of the Southwest Mississippi General Hospital. Also elected were WENDELL HOLMES, vice chief of staff; J. O. WOOD, staff secretary; MARVIN HARVEY and RALPH BROCK, executive committee.

BEN MCCARTY of Jackson announces the removal of his office to 822 Lakeland Drive. Dr. McCarty limits his practice to ophthalmology.

MART MCMULLAN of Jackson and UMC was guest speaker at special honors day ceremonies at Mississippi College.

WILLIAM E. MOAK of Richton attended the District Six Radiological Society meeting at the South Mississippi State Hospital in Laurel recently.

JACK RATLIFF of Jackson and UMC was guest speaker at the recent meeting of the central district of the Mississippi State Society of Medical Technologists at the University Medical Center. He discussed combat paramedical support, drawing on his experience with the Navy in Vietnam.

FREDERICK L. RISHER of Shubuta was elected secretary of the Mississippi Society for the Prevention of Blindness at the ninth annual membership meeting. LYNN D. ABERNETHY and HENRY P. MILLS, JR. of Jackson were elected members of the Board of Directors.

E. G. SCOTT, JR., of Meridian recently conducted a cardiopulmonary resuscitation training course at the Lauderdale County Health Department. Approximately 40 nurses from the area attended.

ROBERT C. TIBBS of Cleveland has received U. S. patent no. 3,352,242 for his invention of an infant feeding apparatus.

JOHN J. WHITE of Jackson announces the removal of his office to 882 Lakeland Drive. Dr. White limits his practice to ophthalmology.

REGINALD P. WHITE of Meridian was featured speaker at a recent seminar on the use and abuse of drugs held at the Hotel Heidelberg in Jackson.

Florida Sets Internist Course

The annual "Topics in Internal Medicine" course will be given May 19-21, 1971, at the University of Florida College of Medicine. This program will consist of three days of intensive lectures, seminars and panels on new and controversial areas of internal medicine.

For complete information and registration forms, write Dr. Mark V. Barrow, division of cardiology, department of medicine, College of Medicine, University of Florida, Gainesville, Fla. 32601.

Dermatological Group To Meet in April

The Southeastern Dermatological Association will meet in Augusta, Ga. April 3-4, 1971.

Dr. Robert Kierland will be the guest clinician and Dr. Richard Reed will be the dermatopathologist. All sessions will be moderated by Dr. Wiley M. Sams.

For further information, contact Dr. J. Graham Smith, Jr., Medical College of Georgia, Augusta, Ga. 30902.

DEATHS

STREET, RICHARD A., JR., M.D., Columbia University College of Physicians and Surgeons, New York 1932; interned Mercy Hospital, Vicksburg, Miss., one year; Ob-Gyn residency Chicago Lying-In Hospital, Chicago, Ill. Nov. 1933-June 1934; died Nov. 23, 1970, age 65.

NEW MEMBERS

BOELENS, PETER A., Vicksburg. Born Hammond, Ind., Jan. 17, 1934; M.D. University of Illinois College of Medicine, Chicago, Ill., 1959; interned Cook County Hospital, Chicago, Ill., one year; pediatric residency University of Minn., July 1, 1967-June 30, 1970; elected Oct. 13, 1970 by West Mississippi Medical Society.

DOWDY, BILLY GENE, Greenville. Born Hayti, Mo., Nov. 9, 1938; M.D. University of Tennessee College of Medicine, Memphis, Tenn., 1964; interned John Gaston Hospital, Memphis, Tenn., one year; radiology residency Methodist Hospital, Memphis, Tenn., Aug. 8, 1965-Aug. 7, 1970; elected Oct. 14, 1970 by Delta Medical Society.

LAMB, WOODROW MCDONALD, Clarksdale. Born Beech Grove, Ark., Dec. 28, 1912; M.D. Tulane University School of Medicine, New Orleans, La., 1938; interned Missouri Baptist Hospital, St. Louis, Mo., one year; ob-gyn residency Chicago Lying-In Hospital, Chicago, Ill., June 1, 1940-Sept. 30, 1940; elected Nov. 4, 1970 by Clarksdale & Six Counties Medical Society.

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n alternative conventional therapy

Efudex (fluorouracil) offers the physician a cal alternative to cryosurgery, electrodesiccation cold-knife surgery in the treatment of solar/actinic atoses. It is effective, comparatively inexpensive and ecially well suited for treatment of these multiple ons. Important, too, is the highly desirable cosmetic ult. Clinical experience demonstrates that treatment n Efudex results in an extremely low incidence of rring.*

ighly effective

In clinical trials, depending on the dosage form strength used, complete involution occurred in o 88 per cent of lesions following treatment. The e of recurrence was low, ranging from 1.7 to 5.6 per t up to a year after completion of therapy. When v lesions appeared, repeated courses of Efudex rapy proved effective.*

redictable herapeutic response

Two to four weeks constitutes a typical course Efudex therapy. The response is usually characteris- and predictable. After three or four days of treat- nt, erythema begins to appear in the area of keratoses. is is followed by an intense inflammatory response, ling and occasionally moderate tenderness or pain. e height of the inflammatory reaction generally occurs o weeks after the start of therapy, and then begins subside as treatment is stopped. Within two weeks of continuing medication, the inflammation is usually ne. A mild erythema may remain for two or three nths before gradually receding. Since this response o predictable, lesions which do not respond ould be biopsied.

wo strengths—two osage forms

Efudex is available as a 2% or 5% solution or a 5% cream. It is applied twice daily by the patient h a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, two im- tant considerations: First, please consult the com- te prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

ata on file, Hoffmann - La Roche Inc., Nutley, New Jersey.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxy propyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing-cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



new
Efudex®
(fluorouracil)
cream/solution

Dr. Yelverton Conducts Flight Instructor Clinic

Dr. Richard L. Yelverton of Jackson discussed the three p's of flying, psychology, physiology and pathology, at the Flight Instructor Clinic held Dec. 1-3 at the Jacksonian Motor Hotel in Jackson.

The Flight Instructor Clinic is sponsored by the Mississippi Aeronautics Commission and is conducted by the Federal Aviation Administration, under the supervision of the FAA general aviation district office for Mississippi.

Dr. Yelverton, UMC clinical instructor in surgery, holds a commercial pilot certificate with instrument rating and a flight instructor-airplane and instrument certificate.

He is a graduate of the University of Mississippi School of Medicine and completed his internship and surgery residency there. He is a member of the American College of Surgeons, the Southeastern Surgical Society, Central Medical Society, Mississippi State Medical Association and the American Medical Association.

Albany Medical College Plans Seminar Cruise

The Department of Postgraduate Medicine of Albany Medical College announces reservations are now being accepted for a spring postgraduate medical seminar cruise to the Mediterranean April 30-May 20, 1971.

The 20-day cruise leaves from New York aboard the luxurious and distinguished ship "Raffaello" of the Italian Line.

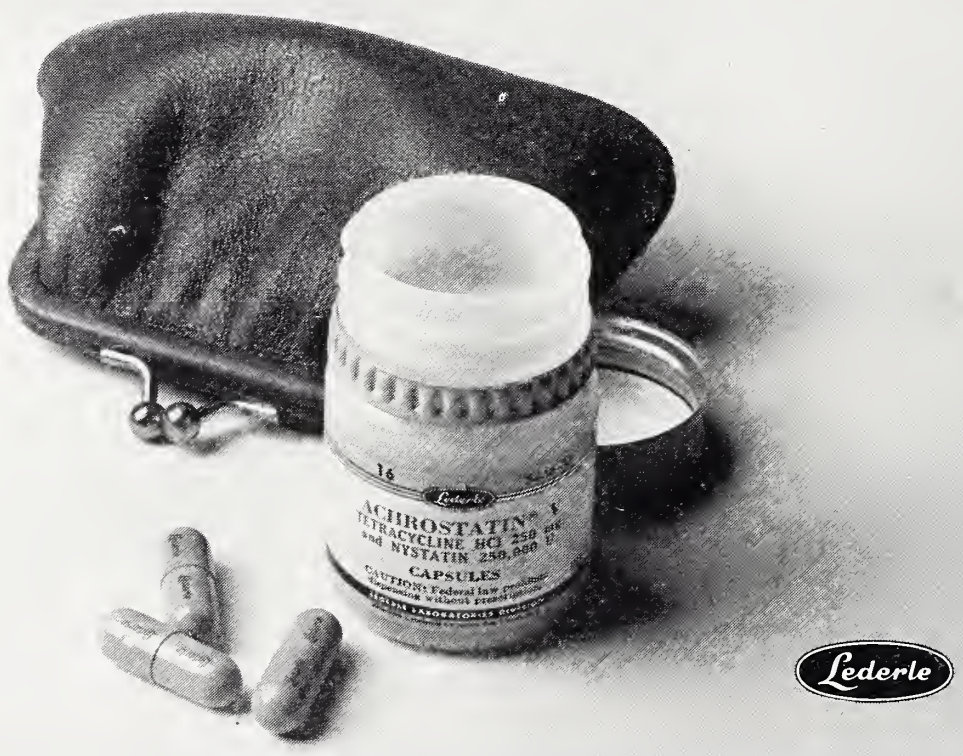
Ports of call include Casablanca, Naples, Genoa, Cannes, Barcelona and Lisbon.

Faculty of the Albany Medical College will present a comprehensive shipboard postgraduate program, covering subjects in internal medicine, cardiology, obstetrics and gynecology, pathology and surgery.

Request has been made for continuation study credit by the American Academy of General Practice.

For information write to: Dr. William P. Nelson, III, Department of Postgraduate Medicine, Albany Medical College, Albany, New York 12208.

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Book Reviews

Atlas of Extraocular Muscle Surgery. By John A. Dryer, M.D., M.S. 180 pages with 19 illustrations. Philadelphia: The W. B. Saunders Company, 1970. $11.50.

This book is a practical guide to ocular muscle surgery. The author has written it out of his experience utilizing, naturally enough, those procedures which have been most effective for him. The text is primarily concerned with descriptions of the surgical procedures.

The approach employed is both logical and precise. Part I is a discussion of the surgical anatomy of the extraocular muscles with well amplified illustrations. Part II, the largest section of the book, is given to descriptions of surgical procedures and is illustrated by excellent diagrams drawn from the surgeon's position for the particular eye designated. The explanations are concise—no loose verbiage here. Some few of the many procedures discussed are: recession of rectus muscle, marginal myotomy, weakening and strengthening the various muscles with the ever explicit drawings showing every step of the procedure.

Part III concerns additional considerations for the procedures mentioned in Part II and further comments. Part IV studies the types of surgical procedures and the indications for them with considerations of esotropia and exotropia, hypertropias and such conditions as paralysis, retraction syndromes, Graves disease, and strabismus fixus.

Part V touches on complications and technical errors which may occur in the procedures while Part VI briefly considers anesthesia.

This book should serve a most useful purpose in that it advances clear guidelines which the eye muscle surgeon might find valuable regarding specific procedures. I should think also that the beginning ophthalmic surgeon would find it of particular value since it is so specific and beautifully illustrated, until he had formulated his own eclectic methodology.

The prose is lucid, the drawings sharply defined, the knowledge well founded. This book is an excellent addition to the field of eye muscle surgery.

No turgid tome this, but a pleasure to examine.

SAMUEL B. JOHNSON, M.D.

The Tetralogy of Fallot From a Surgical Viewpoint. By John W. Kirkland, M.D., and Robert B. Karp, M.D. 189 pages with 88 illustrations. Philadelphia: W. B. Saunders Company, 1970. $13.00.

This monograph, which is highly instructive, examines in detail the almost unrivaled experience of a single group in the management of one of the most common complex congenital cardiac lesions, Tetralogy of Fallot. The subject material is developed well, following a logical sequence which begins with a look at the gross pathology of tetralogy and the relative importance of its components in terms of disorder function and operative correction. Well labeled gross specimens, roentgenograms, and angiograms are used generously to illustrate the untreated lesions ranging over a spectrum of cases which represent the mildest to the most severe types of the deformity.

The geography of hypertrophied right ventricular bands, which produce subvalvular stenosis, is emphasized along with the characteristic location of the ventricular septal defect and its relation to the aortic valve and conduction system. The detailed examination of morphology provides effective preparation for subsequent discussion of the life history of this lesion and its diagnosis.

The angiographic anatomy of tetralogy after palliative or curative intervention is also reviewed and some of the more common associated anomalies of the heart and great vessels are demonstrated. The hemodynamic characteristics of tetralogy are presented in a succinct and straight-

forward manner which is complemented by the use of graphs to demonstrate the effect of exercise, systemic peripheral resistance, and posture on pulmonary blood flow and peripheral arterial oxygen saturation, to mention a few. This information is presented in such a manner that it can be assimilated by those who do not have an extensive background in circulatory dynamics and is correlated well with the life history of the untreated lesion and its diagnosis. Consequently, it should be of considerable interest to those with only an occasional exposure to patients with congenital heart disease.

While the book will be useful to many medical practitioners, it is essential reading for the cardiologist and surgeon who are called upon to deliver palliative treatment or complete correction. The fine points of intraoperative and postoperative management are extremely useful for comparison of one's own program, if indeed not to complement or alter the care which one gives these patients. The information derived from the authors' personal operative experience provides reliable guides for achieving the two major goals of repair, namely the secure closure of the ventricular septal defect without injury to the conduction system and the effective relief of pulmonary outflow tract obstruction. To this end, both the step-by-step procedure for total correction with and without pre-existing palliative shunts as well as the technique of cardiopulmonary bypass (perfusate, conductal perfusion, drug administration, and so on) are described in detail.

The description of treatment in the postoperative period emphasizes the management of problems peculiar to tetralogy following total correction, i.e., low output syndrome, and the relevance of comparative ventricular stroke volumes, mean atrial pressures and other factors. At the same time, it is a fine review of general management of the open heart patient in terms of fluid and electrolyte balance, and the maintenance of optimal cardiac, pulmonary, and renal performance. A review of operative results after total correction is augmented by detailed consideration of surgical failures.

The authors' outstanding survival rate is a testimonial to the expertise that has been obtained throughout the world which in no small part results from their own enormous experience in the management of this lesion. At the same time, recognition is generously given to others in all parts of the monograph for specific advances in the diagnosis, medical and surgical management

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DESCRIPTION	Contents in mg Tablet	Elixir— each 15 ml
phenylpropanolamine HCl	50	25
chlorpheniramine maleate	4	2
glyceryl guaiacolate	200	100
dextromethorphan HBr	30	15
alcohol		10%

The scored, elliptical tablet is light violet. The elixir is deep violet in color and grape-flavored.

ACTIONS Each component of Nilcol has been selected to provide symptomatic relief of congestion and cough in upper respiratory disorders.

Phenylpropanolamine hydrochloride is a vasoconstrictor which reduces congestion of the nasopharyngeal mucosa. Chlorpheniramine maleate, a widely used antihistamine, helps to control allergic symptoms. The expectorant is glyceryl guaiacolate which helps to increase the secretion and decrease the viscosity of fluids of the respiratory tract. Dextromethorphan is a well-known, centrally acting antitussive. Nilcol may minimize the need for topical decongestants.

INDICATIONS Nilcol is indicated for nasal and bronchial congestion; coughs and other symptoms of respiratory infections including influenza and the common cold; other respiratory conditions such as sinusitis, allergic rhinitis or hay fever.

CONTRAINDICATION Hypersensitivity to any ingredient.

PRECAUTIONS Because of the possibility of drowsiness, patients should be cautioned against driving and operating machinery. Administer with caution to patients with hyperthyroidism, hypertensive cardiovascular disease, diabetes mellitus and liver disease. Use in pregnancy is not recommended.

ADVERSE REACTIONS Anxiety, restlessness, tension, insomnia, tremor, weakness, headache, vertigo, sweating, nausea, and vomiting may possibly occur.

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of tetralogy. It is fitting that the information dealing with operative indications is presented almost as a suffix, as if to emphasize the results which are to be expected from the superlative treatment outlined earlier.

The book closes with the description of reconstruction of the hypoplastic or inadequate right ventricular outflow tract as it occurs in pseudotruncus, truncus arteriosus, and pulmonary atresia, one of the most recent advances in surgical correction of congenital cardiac lesions. Thus, the natural history of the disease and its course, as it is altered by palliative treatment and complete correction, is presented in its entirety. The book must, therefore, be considered a classic for its comprehensive consideration of Tetralogy of Fallot and related lesions. It is certainly unique in this area and will stand alone for some time to come.

HILARY H. TIMMIS, M.D.

New Books Received

Atlas of Nuclear Medicine, Lung and Heart Vol. 2. By Frank H. DeLand, M.D., and Henry N. Wagner, Jr., M.D. 284 pages with 810 illustrations. Philadelphia: W. B. Saunders Company, 1970. $20.00.

Extracranial Occlusive Cerebrovascular Disease. By Edwin J. Wylie, M.D., and William K. Ehrenfeld, M.D. 231 pages with 124 illustrations. Philadelphia: W. B. Saunders Company, 1970. $13.00.

Synopsis of Dermatology. By William D. Stewart, M.D.; Julius L. Danto, M.D.; and Stuart Maddin, M.D. 2nd Edition. 445 pages with 193 illustrations and 49 color plates. St. Louis: The C. V. Mosby Company, 1970. $13.85.

The Early Orthopaedic Surgeons of America. By Alfred R. Shands, Jr., M.D. 190 pages with 156 illustrations. St. Louis: The C. V. Mosby Company, 1970. $15.00.

A Synopsis of Pharmacology. By V. C. Sutherland, Ph.D. 720 pages with illustrations. 2nd Edition. Philadelphia: W. B. Saunders Company, 1970. $10.75.

Hernia Repair Without Disability. By Irving L. Lichtenstein, M.D. 210 pages with 113 illustrations. St. Louis: The C. V. Mosby Company, 1970. $26.50.

Medical Pharmacology. By Andres Goth, M.D. 5th Edition. 655 pages with 108 illustrations. St. Louis: The C. V. Mosby Company, 1970. $16.50.

Announcing the Thirty-Fourth Annual Meeting of
THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—The Roosevelt Hotel—March 8, 9, 10, 11, 1971

GUEST SPEAKERS

Chas. Ronald Stephen, M.D., Dallas, Tex.
Anesthesiology
Alejandro F. Castro, M.D., Washington, D.C.
Colon and Rectal Surgery
Alexander A. Fisher, M.D., Woodside, L.I., N.Y.
Dermatology
Thomas P. Almy, M.D., Hanover, N.H.
Gastroenterology
Jack H. Hall, M.D., Indianapolis, Ind.
General Practice
Denis Cavanagh, M.D., St. Louis, Mo.
Gynecology
John T. Galambos, M.D., Atlanta, Ga.
Internal Medicine
Roger F. Palmer, M.D., Miami, Fla.
Internal Medicine
Nathan S. Schlezinger, M.D., Philadelphia, Pa.
Neurology
Ernest W. Page, M.D., San Francisco, Calif.
Obstetrics
Henry F. Allen, M.D., Boston, Mass.
Ophthalmology
Phillip L. Day, M.D., San Antonio, Tex.
Orthopedic Surgery
Edley H. Jones, M.D., Vicksburg, Miss.
Otolaryngology
John A. Shively, M.D., Columbia, Mo.
Pathology
Max D. Cooper, M.D., Birmingham, Ala.
Pediatrics
William B. Seaman, M.D., New York, N.Y.
Radiology
Robert S. Litwak, M.D., New York, N.Y.
Surgery
Edward R. Woodward, M.D., Gainesville, Fla.
Surgery
James F. Glenn, M.D., Durham, N.C.
Urology

Lectures, clinicopathologic conference, round-table luncheons, medical motion pictures, technical exhibits, and entertainment for visiting wives.

This program is acceptable for twenty-two (22) prescribed hours and eight (8) elective hours by the American Academy of General Practice.

(All-inclusive registration fee—$35.00)

For information concerning the Assembly meeting write Secretary, The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

Dr. Posey Elected SMA Section Chairman

Dr. E. Leonard Posey, Jr., of Jackson was elected chairman of the section on gastroenterology of the Southern Medical Association at the annual meeting in Dallas.

Dr. Posey received his undergraduate education at Washington and Lee University and Mississippi College. After graduating from Tulane University School of Medicine, he interned at Touro Infirmary.

Dr. Posey completed his specialty training in gastroenterology and internal medicine at the Mayo Clinic, where he was appointed first-assistant to the staff. He was awarded a postdoctorate degree of master of science in medicine by the University of Minnesota graduate school.

Dr. Posey is certified by the American Board of Internal Medicine and the American Board of Gastroenterology. He is a member of Central Medical Society, Mississippi State Medical Association, American Medical Association, American College of Physicians, and the American Gastroenterological Association.

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House Approves Family Doctor Training Bill

The House of Representatives approved legislation to increase the number of family doctors in the United States. The vote on H.R. 19599, an amendment to the Public Health Service Act, was 346 to 2.

The bill authorizes appropriation of $425 million over a five-year period to support training of family doctors in medical schools and hospital residency programs, training of teachers to teach family medicine, and training of paramedical personnel to assist family doctors to treat more patients in their practice.

Passage of the bill by the House followed passage in the Senate last Sept. 14 by a vote of 64-1. It was approved despite opposition that developed because of the bill's insistence that the money be earmarked specifically for family practice education instead of just being made available to medical schools to use as they saw fit.

The legislation was initially sponsored in the House by Rep. Fred Rooney (D-Pa.). It had earlier been sponsored in the Senate by more than 30 veteran lawmakers. The legislation is endorsed by the American Academy of General Practice, national association of family physicians, and a number of other medical organizations, including the American Medical Association. Testimony had been presented in both Houses of the Congress by the AAGP, AMA and others.

"We are extremely pleased that the Congress has recognized the vital need for family doctors by approving this legislation," said Dr. William E. Lotterhos of Jackson, Miss., president of the AAGP, in commenting on the action, "We are very hopeful that Mr. Nixon will sign the legislation into law promptly so that we can get on with the business of producing more family doctors to take care of the American people."

The legislation acknowledges the continuing decline in the number and percentage of primary care doctors in the U. S. since World War II; points to a method of offsetting this trend, and provides money to underwrite educational programs, Dr. Lotterhos summarized. The residencies are geared specifically to the new specialty of family practice approved by the AMA and other authoritative medical bodies in 1969.

American Hospital Association Gets Into NHI Crusade With Ameriplan Proposal

A special committee of the American Hospital Association has proposed a nationwide system for delivery of health services known as "Ameriplan." The recommended reforms in health care delivery and financing would provide "optimum health care for each and every person."

The 15-member AHA committee, headed by Earl Perloff of Philadelphia, was appointed a year ago to study health care delivery and make recommendations to the AHA House of Delegates, the organization's policy-making body.

Perloff, in making the report public, said that "the committee's recommendations differ significantly from the many proposals that deal only with the financing of health services and fail to provide a solution to the problem of establishing the necessary standards and an organized system for the delivery of health services throughout the nation."

The report states, "As a nation, we must provide better quality, more convenient health care for all the people, at a reasonable cost and in a manner in keeping with human dignity."

The system was named Ameriplan to symbolize the uniting of all health resources of the United States for better care. Ameriplan would revolve around health care corporations set up to provide comprehensive care to specified populations, such as a community or neighborhood.

The corporations would include physicians as well as others in the health care field and, the report said, each corporation would be required to develop a mechanism through which the community would be able to express its health care needs.

Those served by the corporation "would have opportunities for representation in identifying how health services should be provided, in determining how care could best support the dignity of the individual and his family."

The committee recommended that both federal and private funds be used to finance Ameriplan, and said Medicare and Medicaid would no longer be necessary once the new plan is implemented.

It recommended that each state form a health commission to approve and regulate the health care corporations and their operation.

The AHA committee stated its belief in the principle that health care is an inherent, legal right of each individual of the United States, that:

—"It is a function of health care to enhance the dignity of the individual and to promote better community life for all.

—"It is a function of government to assure the preservation and maintenance of the health of the people.

—"Health care must be available without regard to any person's ability to pay and without regard to race, creed, color, sex or age.

—"Health services must be so organized and located that they are readily accessible to all."

Among goals of the plan would be assurance that no person becomes financially dependent or suffers loss of dignity as a result of illness or accident and that all children are provided with preventive health care and that no child suffers from untreated illness.

The plan would provide incentives for treating patients outside the hospital and include in its coverage those suffering from alcoholism, drug abuse and acute mental illness.

A special meeting of the AHA Board of Trustees was held on Dec. 1-2 to study the report. The AHA House of Delegates will give further consideration to the report when it meets in Washington, D. C. on Jan. 25-27.

The other four health care delivery plans now enjoying national prominence are the AFL-CIO Griffiths Program, Committee of 100—Kennedy

Program, Medicare-Javits Program, and the AMA Medicredit Program.

The Griffiths plan, National Health Insurance Act of 1970, would offer total and comprehensive coverage to all U. S. citizens and any noncitizen who has resided in the country for a year. This program visualizes prepaid group systems and capitation payment and would be administered by a National Health Insurance Board.

The Committee of 100 program, formerly known as the Health Security Program, has no co-pay provisions and would be financed from general revenue funds, employer payroll tax, and employee wage taxes. HSP would provide all physicians' services but would place limitations on skilled nursing home and dental services.

The Medicare-Javits Program, an extension of Medicare, would build up to comprehensive coverage of every American by 1973, adding on for the present the disabled, the unemployed, and the poor. Social Security would be the financing vehicle of this program which requires the Secretary of HEW to prescribe standards of education and licensure for providers and the qualifications for performance of major surgery. Although a federal program, HEW could make contracts with states for local administration.

AMA's Medicredit is a three-part program providing basic health insurance for every American. Part A provides for issuance of health insurance certificates based on annual family tax liability. Part B would establish a graduated scale of tax credits applied to health insurance purchase based on individual tax liability. Part C is the now well-known Peer Review Organization (PRO) under which state medical associations willing and able would have statutory priority in contracting for peer review.

The AMA House of Delegates again confirmed Medicredit at the clinical meeting in Boston. In recognizing the AHA committee's proposal, House resolution 66 called for careful study and analysis of the proposed "Ameriplan," which purports to provide for medical care to the public through an interlocking network of corporations.

The AMA reference committee stated, "It appears likely, however, that this proposal, if approved by AHA, may have serious repercussions on the medical profession. Under these circumstances, it is evident that prompt study, evaluation and report is essential."

Cryosurgery Society To Meet

The Society for Cryosurgery will hold its annual meeting March 1-5, 1971, at the Diplomat Hotel and Country Club in Hollywood, Fla. All physicians interested in cryosurgical procedures and techniques are invited to attend.

Cryosurgery in the following specialties will be discussed: general surgery, dermatology, gynecology, neurology, ophthalmology, otolaryngology, and urology.

For further information, write: Secretary, Society for Cryosurgery, 30 N. Michigan Ave., Chicago, Ill. 60602.

RMP-MSU Study Hospital Management

A Mississippi Regional Medical Program-Mississippi State University joint agreement will lay groundwork for a future cooperative hospital management program for hospitals in the state.

Proposed by the Mississippi Hospital Association Board, the $30,000 study is financed by Mississippi Regional Medical Program and conducted by the Mississippi State University Department of Industrial Engineering.

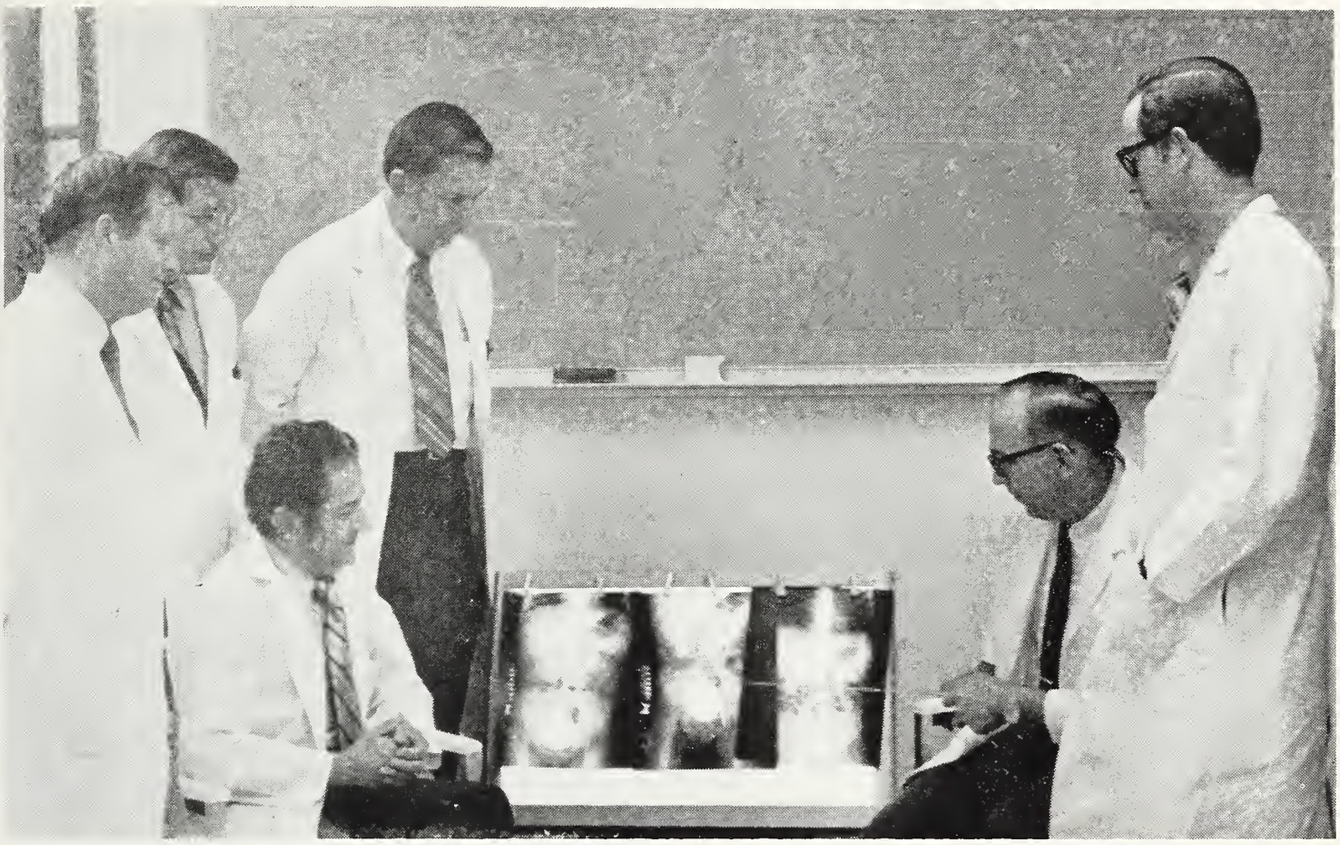
Immediate goal is to study the needs of hospitals in the state for management engineering services, examine similar successful programs in other states and make recommendations for an in-state program.

Dr. L. Ray Johnson, industrial engineering associate professor, heads the study team, with Dr. Jesse H. Oswalt, also associate professor, as systems analyst. The staff will visit multihospital management engineering organizations in nearby states, as well as Mississippi hospital administrators.

Guided by the team's findings, the long-range project will be aimed at checking spiraling hospitalization costs while improving the quality of care through more efficient use of existing resources. Additionally, if future program personnel are needed, Mississippi State University will consider initiating a hospital management training and services program within the Department of Industrial Engineering.

The projected management services will be available to Mississippi's 128 hospitals.

Five Doctors Take Pediatrics Course



Five state family physicians were enrolled in the first session of the Mississippi Postgraduate Institute in the Medical Sciences pediatrics intensive course at the University Medical Center in November. They are, standing from left, Dr. Thomas B. Whitehead of Columbia; Dr. Thomas J. Anderson, and Dr. James C. Waites, both of Laurel; Dr. J. S. Poole of Centreville (seated at right), and Dr. Charles O. Williams of Jackson (standing, right). Dr. J. M. Montalvo, associate professor of pediatrics, seated at left, was a course coordinator. The year's second pediatrics session is set April 5-9, 1971. Mississippi Regional Medical Program supports the Institute.

M.D. Gets Medical-Nursing Appointment

Dr. James A. Alford has become the first person to receive an appointment as assistant dean of both the medical and nursing schools of Emory University.

According to a joint announcement by the deans of the two schools, Dr. Alford will serve in a liaison capacity to coordinate service-oriented projects undertaken by the faculty members of both schools.

He will also be responsible for starting new health-care programs which require the cooperation of nurses and physicians.

"We'd like to demonstrate," said Dr. Alford, "that it's possible for the two professions to work together both independently and interdependently. For example, we would like to make it possible for the nursing faculty to practice nursing in the same sense that the medical faculty can practice medicine."

He emphasized that to "practice nursing" does not mean that nurses would "practice medicine" or assume duties that physicians should perform. The nurse quite properly can help to carry out a plan of treatment prescribed by a physician, however, and this might be done in a variety of settings, including consultations at the nurse's office, visits in patients' homes, or by visits to patients in hospitals and other institutions, Dr. Alford said.

"One of our goals is to show that nurses with baccalaureate and higher-degree training have professional skills which permit them to act both independently and interdependently in caring for patients," Dr. Alford said.

Another of his duties will be to find ways of financing service-oriented projects of a cooperative nature in medicine and nursing.

Medical Center Adds to Faculty

Dr. Mohamed Abdel-Salem Mobarak has joined the University of Mississippi School of Medicine faculty as assistant professor of clinical laboratory sciences.

A native of Egypt, Dr. Mobarak holds the M.D. degree from Cairo University, where he did his internship and residency. He was also a resident at Queens' Hospital in Canada and a fellow at the University of Pennsylvania. Former chief of the medicine department at Alexandria General Hospital in Alexandria, Egypt, Dr. Mobarak was an instructor at the University of Pennsylvania prior to his Mississippi appointment.

Other School of Medicine appointments include obstetrics and gynecology associates Dr. Albert W. Dumas, Jr., and Sister Mary Bernice Buckley.

ACP Inducts 16 State Physicians

Sixteen Mississippi physicians who have met the standards of the American College of Physicians (ACP) have been granted Fellowship or Membership in that 54-year-old international medical specialty society.

New Fellows from Jackson are Drs. Ben B. Johnson and Herbert G. Langford. Selected as Members are Drs. Kenneth R. Bennett, Joseph L. Glasgow, James C. Hays, Richard G. Hutchinson, Sylvester H. McDonnieal, Jr., Larry M. Mitchell, Roland B. Robertson, Jr., and Robert E. Tyson.

Dr. John R. Shell of Vicksburg and Drs. David M. Owen and Frederick E. Tatum of Hattiesburg are also new Members.

Three physicians from Keesler Air Force Base at Biloxi were inducted into the College: Lt. Col. Robert O. Amdall, USAF, MC; Lt. Col. Henry P. Meijer, USAF, MC; and Maj. William P. Munsell, USAF, MC.

The new Fellows have earned this distinction through certification by specialty boards, presentation of published material and evidence of scientific accomplishments and academic or hospital affiliations. New members graduated from medical school at least five years ago and have limited their practice to internal medicine or a related specialty and have submitted evidence of their eligibility to take specialty board examinations.

Dr. Field Joins MSMA 50-Year Club

Dr. Richard Jennings Field, Sr., of Centreville received his MSMA Fifty-Year Club certificate and pin at the Wilkinson-Amite County Medical Society quarterly banquet meeting. Dr. Jack Q. Causey, chief of staff of Field Memorial Community Hospital, made the presentation.



Dr. Jack Q. Causey, at right, presents Dr. Richard J. Field, Sr., of Centreville with the MSMA Fifty-Year Club pin and certificate at special ceremonies recently.

Dr. Field graduated from Tulane School of Medicine in 1920 and received surgical training under Dr. Rudolph Matas at Touro Infirmary. Dr. Field has served as director of the Field Clinic for many years and has been chief of staff of the Field Memorial Community Hospital.

He is a member of the Southeastern Surgical Congress, American Medical Association, Mississippi State Medical Association, and a Fellow of the American College of Surgeons. He also served as first president of the Mississippi Hospital Association.

ACS Sets March Doctor-Nurse Meeting

The 18th combined meeting for doctors and nurses sponsored by the American College of Surgeons will be held in New Orleans, March 15-17. The meeting is open to all doctors of medicine and registered nurses. Headquarters hotels are the Fairmont Roosevelt and Jung. More than 2,500 are expected to attend.

Scope of the meeting will approach that of the annual clinical congress, with sessions in general surgery and nine surgical specialties: orthopedic surgery, gynecology-obstetrics, otorhinolaryngology, pediatric surgery, neurologic surgery, plastic surgery, ophthalmic surgery, thoracic surgery and proctology. Speakers will focus attention on newer ways of handling problems. Also, some 25 medical films and approximately 50 industrial exhibits of new equipment and accessories useful to the medical profession will be shown.

A report on "Present Activities and Future Direction of the College" will be presented by Dr. C. Rollins Hanlon, Chicago, director, American College of Surgeons, on the opening morning. Dr. Howard Mahorner, New Orleans, president of the College, will preside at this first session.

Nurses' concurrent sessions will cover breast tumors, post-anesthesia room, pediatric nursing problems, liability coverage for nurses, surgical technicians, cardiovascular surgery, and psychological aspects of nursing.

Dr. Walter F. Becker, New Orleans, is chairman of the physicians' program committee. Assisting him are general surgeons Isidore Cohn, Jr., Theodore Drapanas, Elmo J. Cerise, Claude C. Craighead, Norman C. Nelson and Howard Mahorner.

Hotel reservation forms may be obtained from Mr. T. E. McGinnis, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611. No registration fee is charged Fellows of the College, members of the Candidate group, residents or interns who present letters signed by chiefs of surgery or hospital administrators. Nurses pay no registration fee. Non-Fellows pay $15; non-Fellows in the Federal Services pay $7.50.

Dr. Edwin W. Gerrish, Chicago, ACS assistant director, is in charge of scientific programs for all College meetings.

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Behavioral Sciences Bibliography Published

The first major attempt to highlight the most important references to the research literature on adaptation and coping behavior in human development, has been issued by the National Institute of Mental Health, Health Services and Mental Health Administration.

The compact volume "Coping and Adaptation —A Behavioral Sciences Bibliography," is designed to be of aid to research scientists, clinical practitioners, and community mental health workers seeking a guide to information relevant to their work in the areas of psychotherapy and counselling, rehabilitation, and crisis intervention.

It represents a long-term collaborative effort between government and university scientists. Editors were Dr. George V. Coelho of NIMH; Drs. David A. Hamburg and Rudolph Moos of the department of psychiatry, Stanford University School of Medicine; and Dr. Peter Randolph of Tufts Mental Health Clinic in Boston.

Citations were selected from more than 500 suggested by some 80 behavioral scientists, from several hundred obtained from the editors' own reference lists, a MEDLARS print-out of titles supplied by the National Library of Medicine, abstracts from the Science Information Exchange, and citations in *Psychological Abstracts*. The 425 most pertinent citations were selected for the bibliography.

Emphasis is given to recent research covering readily-available articles and monographs published through 1967. Books, unpublished technical reports and foreign journals are not represented.

The bibliography illustrates "the multidisciplinary scope of basic and applied research in this broad subject. It is hoped that its availability in the present format will encourage behavioral scientists to explore unifying themes in diverse and seemingly disparate areas of mental health research on coping behavior in stress."

The abstracts are in alphabetical order according to the name of the senior author. There is a comprehensive subject index.

Copies are available at $1.75 each from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. It is Public Health Service Publication No. 2087.

Emergency Physicians Meet in Las Vegas

The American College of Emergency Physicians held its second annual meeting at Hotel Sahara in Las Vegas recently.

In attendance were 650 physicians, hospital administrators, nurses and other paramedical personnel interested in emergency medicine. A total of 12 speakers presented scientific sessions while a panel of seven physicians teamed up as resource personnel during panel discussions.

A general assembly of the members of ACEP was held prior to the Scientific Assembly and elected a 14-man Board of Directors.

The site for the 1971 ACEP annual meeting will be Miami Beach, Fla. The program, scheduled for next October, will review up-to-date methods and techniques in the delivery of acute medicine. Technical, scientific and educational exhibits will be on display.

Additional information about the college may be obtained by writing the ACEP headquarters, Arthur E. Auer, Executive Secretary, 120 W. Saginaw, East Lansing, Mich. 48823.

NIH Publishes Foot Disease Booklet

"Feet First," a colorful, illustrated, question and answer booklet to help older people and diabetic patients of all ages avoid the consequences of foot infection has been published by the Division of Nursing, Bureau of Health Professions Education and Manpower Training, National Institutes of Health.

Presented in large, easy-to-read type, this self-instructional course of basic information helps patients to understand how the body tissues receive their nourishment; the role and importance of circulation; the special attentions their feet require; and daily do's and don'ts for promoting foot health and preventing serious foot complications. It serves further as a tool for teaching nursing aides and home health aides the rudiments of foot care for elderly and diabetic patients.

Supplies of "Feet First" may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, at 60 cents a copy. A single complimentary copy may be obtained from the Division of Nursing, 9000 Rockville Pike, Bethesda, Maryland 20014.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 20-24, 1971, Atlantic City, Clinical Convention, Nov. 28-Dec. 1, 1971, New Orleans. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

STATE AND LOCAL

Mississippi State Medical Association, 103rd Annual Session, May 3-6, 1971, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Mississippi Academy of General Practice, Annual Assembly, June 24-26, 1971; Biloxi. Miss Louise Lacey, Executive Secretary, P.O. Box 3112, Jackson 39207.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Robert P. Henderson, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday, April and First Wednesday, November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 1237, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, President.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. James E. Booth, Eupora, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday. April and October. Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. M. Howell, 139 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. A. Robert Dill, 1001 Main Street, Columbus, Secretary.

Singing River Medical Society, Third Monday, January, March, June, September, and December. Donald E. Dore, Singing River Hospital, Pascagoula, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. W. B. White, Medical Arts Bldg., Laurel, Secretary.

West Mississippi Medical Society, Second Tuesday, January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.

UMC Children's Hospital Has Open House

A crowd of nearly 400 attended the November open house at the University of Mississippi Medical Center children's hospital.

With a special invitation extended to youngsters across the state, the open house was designed to give the general public a first-hand look at the unique round pediatric facility. Guests, including health agency heads, city and state officials, toured the children's center and met hospital staff members.

Doctors Warned of Mounting Drug Abuse

More than 1,400 doctors in the New York area were told that if America does not solve its mushrooming drug addiction problem within the next ten years our civilization may find it difficult to survive.

The grim warning was sounded by a distinguished panel of psychiatrists and physicians speaking at a symposium on drug abuse sponsored jointly by the New York Academy of Medicine and Pfizer Laboratories at the Americana Hotel.

The increase in addiction, these experts said, is geometric and is already out of hand because there is no clear-cut or apparent solution. In New York City alone, it was reported, there were 900 deaths last year from drug overdose.

The panel made these essential points:

(1) Education, whether it be lectures to the public or classes for children, has little effect. Young drug users lack motivation to stop and motivation must be supplied before a cure can be effective.

(2) Physicians see a growing menace in the misuse of non-narcotic drugs intended for other uses such as amphetamines, tranquilizers and sleep hypnotics. Amphetamines may be prescribed by physicians for obesity or lethargy; the patient enjoys the stimulation derived and continues to use the drug if the physician is not alert in regulating and curbing the supply. Some common tranquilizers are addictive and present withdrawal problems. A number of these drugs potentiate each other and alcohol to the extent that it has become a growing method for suicide—the most used method with women.

(3) Drug addiction is contagious and epidemic. Users infect others. In Sweden, addicts are doubling in number every 30 months except for one period when the government relaxed restrictions and the number doubled in 12 months.

(4) Lumping marijuana with other drugs contributes to present legal problems of enforcement. Marijuana does not appear to be physically addictive but creates psychological dependence, although the extent is difficult to gauge. It does not appear to incite the user to violence, as amphetamines often do.

(5) The number of prescriptions written for minor tranquilizers and barbiturates where not really indicated should concern the medical profession and an all-out effort should be made to reduce unneeded family stockpiles of these medications. Children may be tempted to experiment with drugs found in the family medicine cabinet.

(6) Not only the patient, but the physician can be addicted, since the physician because of his training and experience is susceptible to the taking of drugs for a troublesome condition. The physician must be sure, in prescribing a tranquilizer, that the patient's anxiety is at a level to warrant the use of a drug. He must be sure to regulate the supply and not continue it indefinitely.

Chairman of the symposium was Dr. Jerome Jaffe, associate professor, Department of Psychiatry, University of Chicago. His major interest is in the use and abuse of psychoactive drugs, particularly the biological and sociological aspects.

Panelists were: Dr. Nils Bejerot, a social psychiatrist of the Stockholm County Council, a member of the National Swedish Medical Research Board, and one of the world's leading authorities on amphetamines; Dr. Donald Louria, professor and chairman of the Department of Public Health and Preventive Medicine at the New Jersey College of Medicine and Dentistry (He is the author of "The Drug Scene."); Dr. Sidney Cohen, president-elect of the Academy of Psychosomatic Medicine, past Director, Division of Narcotic Addiction and Drug Abuse of the National Institute of Mental Health and former Associate Professor of Medicine at UCLA (He is the author of many works on drug abuse, including "The Beyond Within," "The LSD Story," and "The Drug Dilemma."); Dr. John Kramer, professor in the Department of Psychiatry at the University of California at Irvine (He has written extensively on drug abuse and is an expert in the field of amphetamines.); and Dr. Soloman H. Snyder, professor at Johns Hopkins University School of Medicine.

Five Counties Named Health Demostration Area

The Appalachian Regional Commission has designated a five-county area in Appalachian Mississippi as a health demonstration area.

Counties to be included in the health demonstration area are Chickasaw, Itawamba, Lee, Monroe, Pontotoc, and Union. Two non-Appalachian counties (Calhoun and Lafayette) will be included in the state health program but will receive no Appalachian funds.

The Appalachian Regional Commission's health program operates in nine other Appalachian states and has seen marked success in upgrading the health and hygiene of Appalachia residents.

MHA Sponsors Hypertension Testing

Over 500 employees of Erwin Mills in Stonewall were tested for high blood pressure recently in the state's first mass health screening in industry.

The heart associations of Lauderdale and Clark counties sponsored the one-day project, which was designed to screen as large a number of people as possible for hypertension, focus of the American Heart Association's early detection campaign this year.

This screening was conducted on a volunteer basis and 524 of the plant's 628 employees participated.

Of the 524 tested, 78 were found to have hypertension and were referred to their own physicians. Prior to this screening, 50 persons in this group were unaware of the fact that they had a blood pressure problem.

Registered and practical nurses from both counties checked each participating employee's blood pressure and pulse count. Drs. Jetson P. Tatum of Meridian and Walter Gunn of Quitman, two of the project's directors, were on hand to refer employees with hypertension to their own doctors.

Also directing the project was Everitt Crudup, chairman of District 12 of the Mississippi Heart Association.

Before prescribing, please consult complete product information, a summary of which follows:
INDICATION: Relief of insomnia of varied etiology.
CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.
Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.
Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.
PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.
ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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Merrell Plans New Office Building

A new office building costing in the range of $2.5 million will be constructed by The Wm. S. Merrell Company, Division of Richardson-Merrell Inc. it was announced by John S. Scott, president of the Merrell pharmaceutical division, and Dr. Robert H. Levin, vice president for research, Richardson-Merrell Inc.

Construction of the multi-level facility providing approximately 60,000 additional sq. ft. will begin promptly. The building will be completed early in 1972 and will face Amity Road at the Merrell location in Reading, Ohio.

The new building, which will be part of the Merrell research complex, will provide an expanded area for the scientific library and technical information systems units, a biostatistics center, and offices for research management and clinical research personnel, as well as for Merrell general management and marketing groups.

Architects for the building are Baxter, Hodell, Donnelly & Preston, 3500 Red Bank Road, Cincinnati. The architects have designed a highly functional, modified Z-shaped structure. It will be a combination of brick and tinted glass thermopane curtain wall.

The new structure will be joined to the present Merrell research laboratory building which was enlarged in 1964. Space occupied in the present building by medical and research management will be vacated and converted to research laboratories. This is according to the original long-range plan.

Dr. Robert H. Levin, vice president for research, Richardson-Merrell Inc., recently announced consolidation in Cincinnati of the corporation's research programs concentrating on pharmaceutical research for prescription drugs.

NIMH Studies XYY Chromosome Abnormality

Research has not yet established a definite causal link between the XYY chromosomal abnormality and deviant, criminal, or violent behavior, according to a report released by HEW's National Institute of Mental Health, of the Health Services and Mental Health Administration.

"It (is) not possible to say at the present time that the XYY complement is definitely or invariably associated with behavioral abnormalities," the report states. "Quite clearly, very complex and varied interactions between hereditary and social and environmental influences appear to be involved. Further, it seems unlikely that such variable and socially defined and determined problems as delinquency and crime are primarily and directly linked with the possession of an extra Y chromosome."

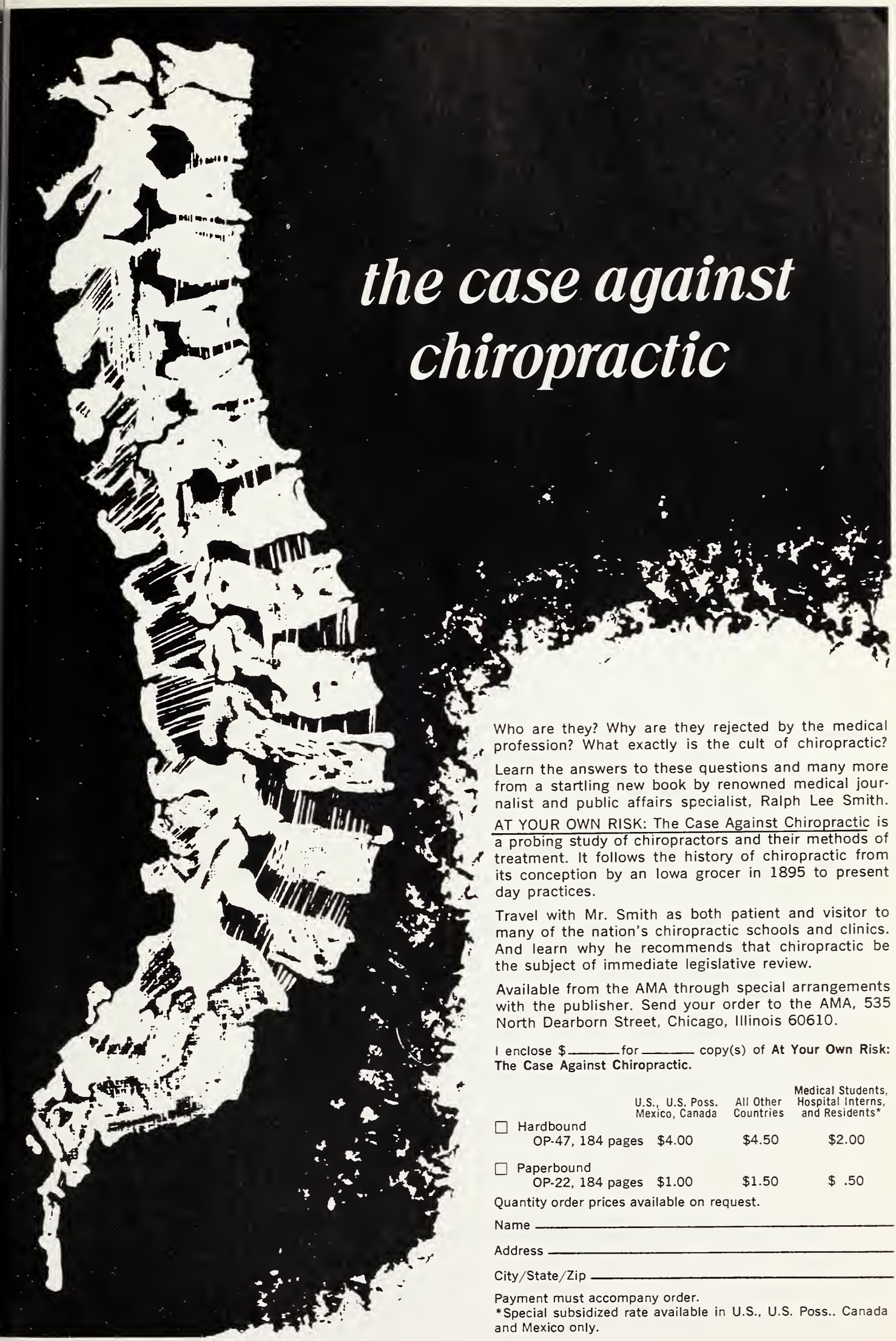
Upon releasing the report, Dr. Bertram S. Brown, NIMH Director, commented: "This up-to-date and comprehensive summary of current knowledge on the XYY chromosomal anomaly clearly indicates that the belief which seems to have been accepted in some segments of the general public and of the scientific community that males with this genetic abnormality are more or less inevitably predisposed toward violent or criminal behavior, is premature and is not supported by available scientific evidence."

The Report on the XYY Chromosomal Abnormality is based on a June 1969 conference of experts from the fields of genetics, psychiatry, psychology, sociology, and law, brought together by NIMH for in-depth discussions of XYY research findings to date, outstanding gaps in knowledge, research methodologies for future studies, and socio-medico-legal issues related to this anomaly. Information in the report has been updated to include results of research published since the conference.

On the basis of available studies, the only general statement which could be made at this time is that "the individual with an XYY chromosomal anomaly appears to incur some increased risk of developing behavioral problems, in comparison to XY (normal) males," the report says. "There is no reason to believe that an XYY male is inexorably bound to develop antisocial traits or behavioral problems."

Dr. Brown said: "The experts who met to review this matter concluded that until more precise knowledge is available, social judgments about the XYY individual based on his chromosomal constitution are unjustified. Further research information on the many factors involved is very much needed."

According to the report, the first major deficit in our understanding of the XYY phenomenon pertains to the absence of precise and adequate data on its incidence (the rate of occurrence at birth) as well as prevalence (the total number of cases at a particular point in time) in the general population.



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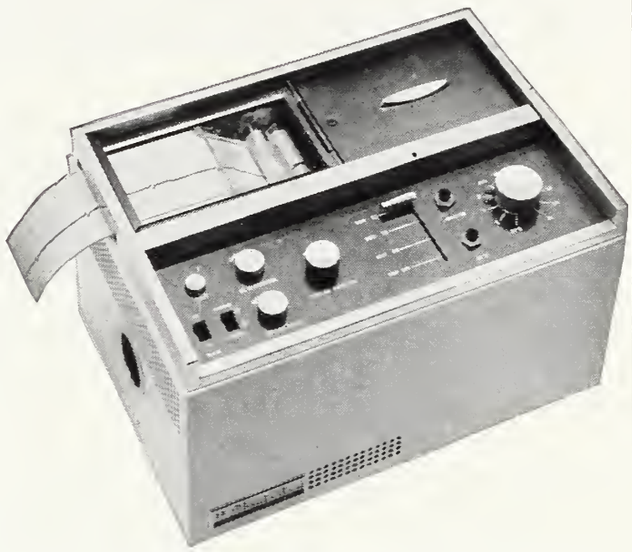
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IN CONCLUSION

For the man who has everything, including a vasectomy, there is a new lapel pin. The Association for Voluntary Sterilization is selling pins "for men who have had vasectomy and are proud to let people know about it." Design is familiar male symbol of circle with arrow at 1:00 o'clock, except that circle is broken on left side and has word "vasectomy" across lower arc. AVS says pin is gold finish with blue enamel, postpaid for $1.

AMA Physician's Recognition Award for achievement in postgraduate medical education now goes on application to members of American Academy of General Practice who have been on AAGP rolls for three years and have been recertified at least once. AMA award is given for 150 hours of postgraduate medical education in three year period. State medical association program has stiffer minimums, requiring 80 hours formal and 30 hours elective training annually.

The third class of Certified Medical Representatives has been graduated by the new institute dedicated to giving professional service reps or detail men chance to earn professional status. Curriculum is tough and demanding, adding substantially to knowledge already possessed by drug company representatives. Program is one of self-improvement sponsored by Certified Medical Representatives Institute of Roakoke, Va., with industry support.

Controversial Report of President's Commission on Obscenity and Pornography, heavy with medical overtones, is getting into the news for another reason. The 1,000 page report, available as a government document, is selling for as much as $20 per copy in eastern states saloons and honky-tonks. Reason: It's pretty pornographic itself. Report of commission appointed by LBJ has been denounced and rejected by Nixon administration.

Food and Drug Administration has been roundly censured by House Committee on Government Operations. Committee charges that FDA did not follow its own rules in policies on Rx drug advertising to M.D. and has "confused policies." Report was result of four-year study by committee headed by Rep. L. H. Fountain (D.,N.C.). Drug industry does not escape committee wrath for some past advertising and marketing practices.

Volume XII
Number 2
February 1971



JOURNAL of the Mississippi
STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $7.50 per annum; $1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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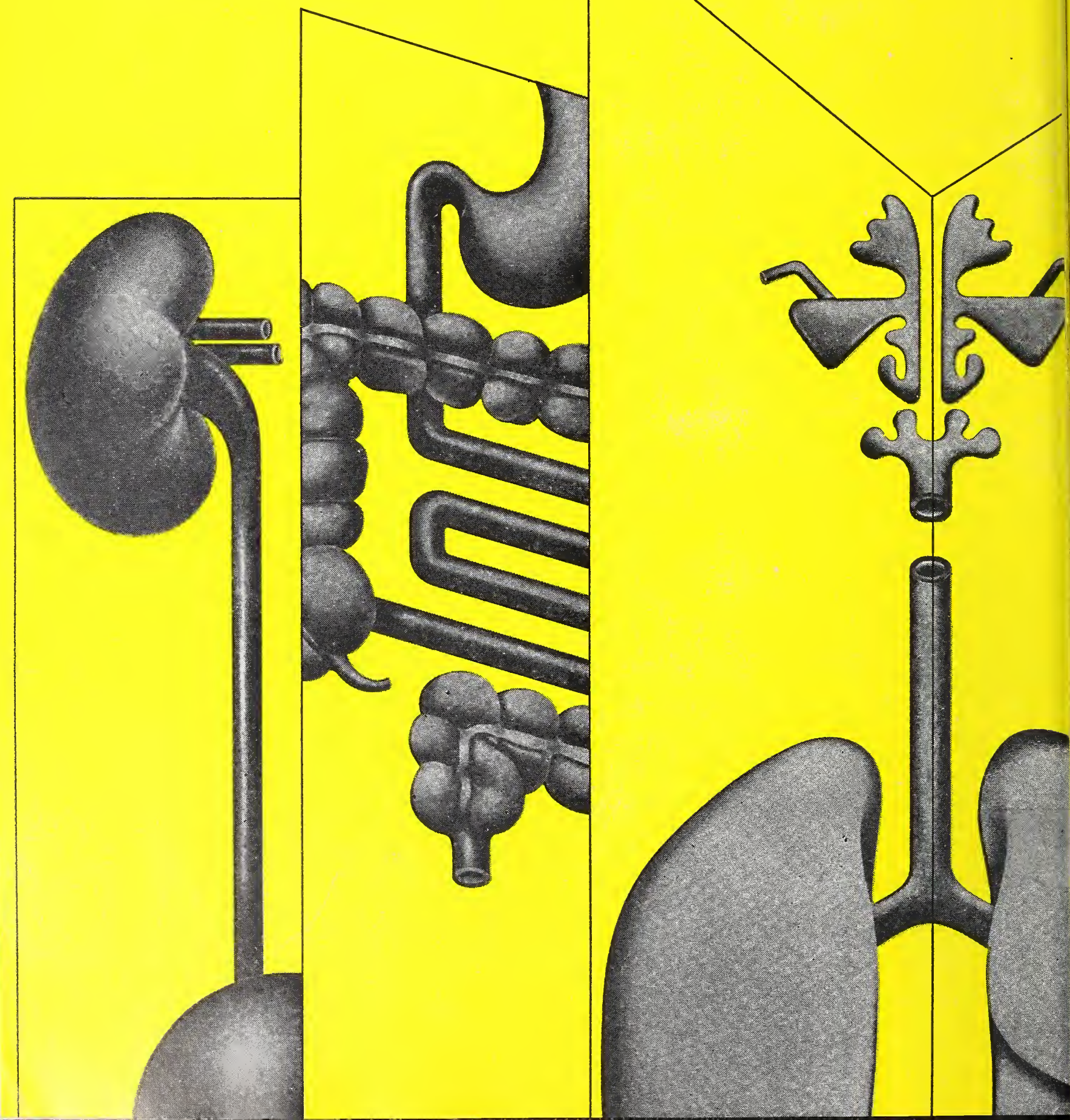
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Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used and serum estimations may be necessary during prolonged therapy. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

Precautions: Mycotic or bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. Cases of gonorrhea with a suspected primary lesion of syphilis should have darkfield examinations before receiving treatment. In all other cases where concomitant syphilis is suspected, monthly serological tests should be performed for a minimum of 4 months.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.

Usual Adult Dose: One Gm./day in 2 or 4 equally divided doses. Continue therapy for ten days in Group A beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

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Socio-Economics Congress Set

The fifth national Congress on the Socio-Economics of Health Care will be held at Caesar's Palace in Las Vegas April 2-3, 1971.

Sponsored by the AMA Council on Medical Service, the Division of Medical Practice, the theme of this year's congress will be current issues in medical care delivery.

Participants will explore existing projects and programs designed to improve physician productivity and promote efficiency in the health care system by examining foundations for medical care.

They will also investigate electronic data processing applications to the economics of health care and identify the status of federal legislation and its potential impact on the organization, financing and delivery of health services.

Reservations must be received by Caesar's Palace no later than March 8, 1971.

Wine and Health Writing Contest Set

A new contest which recognizes outstanding communications about wine and health has just been announced.

One thousand dollar prizes will be awarded in three categories for works which tell of the health aspects of wine and appeared during the fiscal year extending from last July 1 to next June 30.

According to the announcement, the prizes will be awarded for articles published in public newspapers and magazines; in medical publications; and, for radio-television broadcasts.

Judging the entries will be three eminent medical editors: Dr. Theodore Van Dellen, syndicated columnist and editor of *Illinois Medical Journal;* Dr. Charles G. Roland, chairman, department of biomedical communications, Mayo Clinic; and president of the American Medical Writers Association; and Byron T. Scott, editor of *Today's Health* magazine, published by the American Medical Association.

Deadline for submission of entries is July 31, 1971. Details of the contest are available from the Administrator, Wine and Health Writing Awards, Suite 1307, 703 Market Street, San Francisco, Calif. 94103.



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NEWSLETTER

February 1971

ar Doctor:

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y with support of state medical association and college board.
en only to B.S. nurse graduates, program will require didactic
rk of 30 semester hours with 15 in general education and 15 in
rsing. Applicants must also meet general admission standards
r enrollment in Ole Miss Graduate School.

Faustena Blaisdell, Ph.D., professor of nursing and di-
rector of graduate study, heads program. Initial cur-
riculum is part-time, but beginning with summer session
next June, graduate nurse students will be enrolled on
a full-time basis.

esident Nixon and the Congress surprised everybody on new en-
tment establishing National Health Service Corps under USPHS.
asure will send physicians into the rural areas and inner city
ettoes where shortage of practitioners is most acute, and those
assigned will be exempt from Doctor Draft and military service.
ll's sponsors didn't expect it to pass or President to sign.

A has charged discrimination against physicians by HEW and Social
curity in new regulations on Medicare fees. Change would revise
e base to 75th percentile of 1969 usual and customary fees from
esent 83rd percentile of 1968 charges. Revision is academic and
etorical, really resulting in little or no upgrading. Hidden
ker is that inflation ate up 9.5 cents of dollar in 1970.

most nobody is left to get into the national health insurance act
w that health insurance industry has unveiled its new Healthcare.
ea is two programs of coverage, one government-subsidized for the
or and other, a private contract for those who can pay. Industry
uld dip into federal treasury for $3.2 billion per year. Program
uld involve pooled risks and uniform national care standards.

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ght-day junket takes advantage of weekends, requiring only five
ys away from practice. Travel by DC-8 jet, deluxe hotel, meals,
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February 24, 25, 26, 1971

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References:
1. Duvoisin, R. C., *et al.*: *Trans. Amer. Neurol. Assoc., 94*: 81, 1969.
2. Cotzïas, G. C.: *J.A.M.A., 210*:1255, 1969.

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HEW Sponsors Ambulatory Survey

The National Center for Health Statistics in the Department of Health, Education, and Welfare, as part of its continuing program to provide data on the health status of the American people, is currently planning the National Ambulatory Medical Care Survey (NAMCS). The purpose of the NAMCS is to collect objective, quantitative information which can be used to describe the types of ambulatory patients seen by physicians, the nature of the patients' problems and the resources for their care. This information is needed by leaders in medicine and related professions for planning and organizing health services, for planning efficient utilization of health facilities and manpower, and for determining modifications in medical education.

The survey will involve a national sample of physicians who will be requested to provide data concerning a small number of the ambulatory patients they see. When the NAMCS is in full operation (sometime in 1972), about 3,000 physicians each year will be providing data on an estimated 240,000 ambulatory patient visits. Physicians selected to participate in the survey will provide information concerning a sample of the patients that they see during a two-day period in each of four consecutive calendar quarters. All physicians will be replaced by new sample physicians after participating for four quarters. The types of data the survey will collect include age, sex, and medical problems of patients plus treatment prescribed and laboratory tests performed for patients. Of course, all data will be held completely confidential and used only for statistical purposes.

Ambulatory medical care is by far the largest segment of the American health services system in terms of prevalence and volume. Yet, little has been done on a national scale to gather reliable information for use in planning and research. The dearth of information on this subject has led leaders in the medical profession to persuade the National Center for Health Statistics to undertake the National Ambulatory Medical Care Survey. This information will complement the health data already being obtained by the center through its ongoing national surveys: the Health Interview Survey, Health Examination Survey, and Hospital Discharge Survey. The success, of the NAMCS, of course, will depend on the cooperation of practicing physicians who are the major source of ambulatory medical care data.

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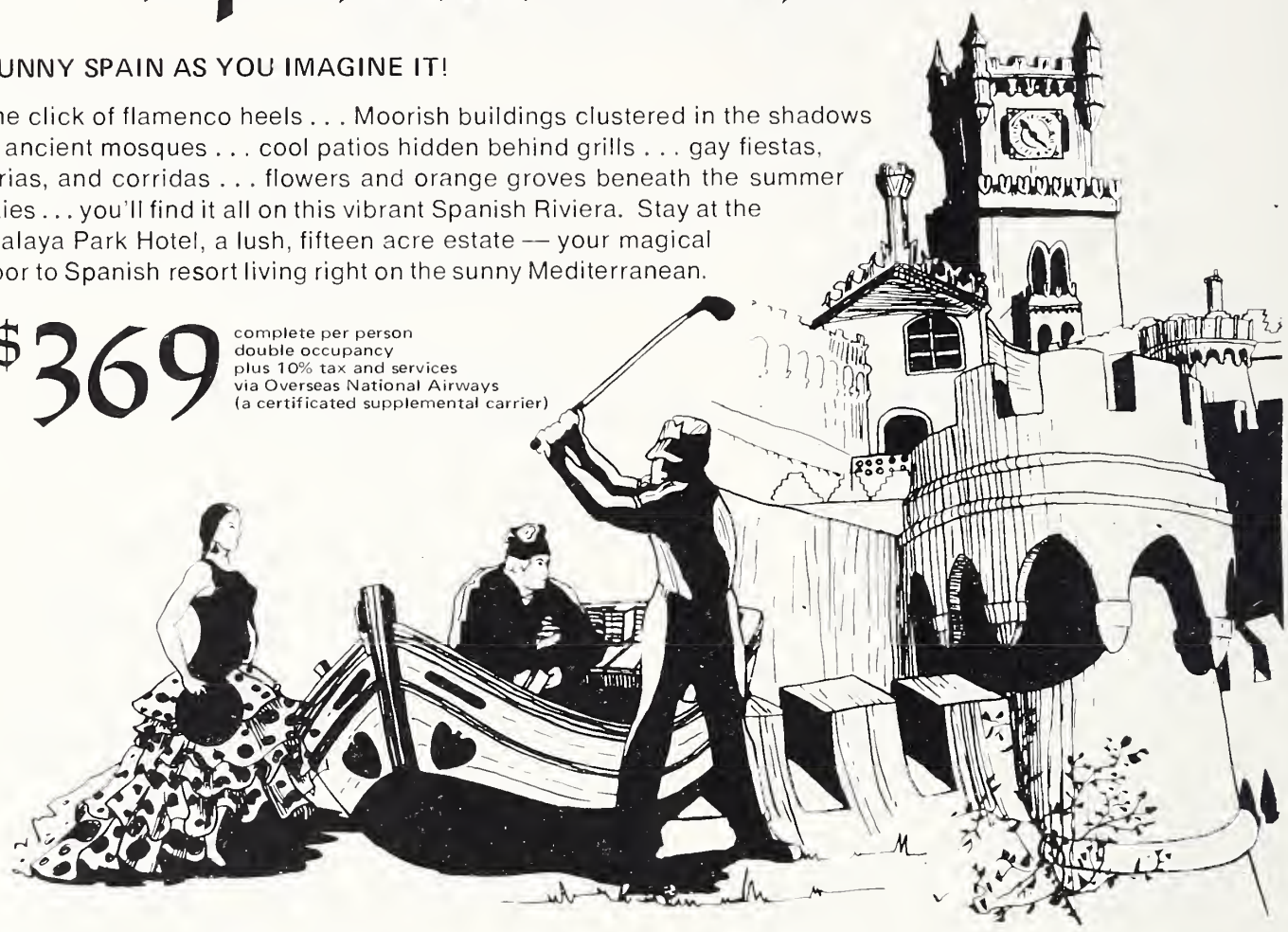
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DATELINE

rsing Home Chiefs .ce Licensure

Jackson - Nursing home administrators must take licensure examinations or lose entitlement to manage care facilities. Requirement r licensure is in 1969 Social Security amendments but is under ws of state. Administrators not licensed in January must take 0 hours of training to retain status with provisional licenses. ogram calls for stiff fees of $100 plus examination fee of $25. rpose of license is to assure quality of facilities management.

Nurses Seek actice Autonomy

Albany, N.Y. - New York State Nurses Association has shaken up health care community with drastic amendments to practice act. Measure lineates "the independence of the nursing function...the ability the nursing practitioner to function autonomously rather than der the direction of the physician." Amendments also limit N's to tasks "as are delegated by the profession of nursing." gislative debate on bill is certain to stir major controversy.

S. Death Rate ops Again in '70

New York - Metropolitan Life actuaries see 1970 as one of the best years yet for life in the United States. Overall mortality declined 9.4 per 1,000 from 9.5 in 1969, the 23rd consecutive year below per 1,000 population. Infant mortality dropped to record low 21 per 1,000 live births, and final figures may show it was under 20. Most astonishing, however, is that infant deaths declined per cent from 1960 to 1970 against 15 per cent in 1950 to 1960.

MA Sues State ver Medi-Cal Cut

San Francisco - The California Medical Association has filed suit against state of California to rescind cutback in Medi-Cal (Medicaid) program ordered to avert alleged $200 million deficit. CMA contends hat intent of legislature in Medi-Cal enactment was to deliver are and that slash in name of economy could even result in deaths. estrictions cut patients to two physician visits per month, reices Rx drugs, and allows only two psychiatric visits per year.

mputers Assure ptimum Blood Use

Chicago - Control and management of blood banks by computers is being successfully operated at Michael Reece Medical Center and on other side Atlantic by Netherlands organizations. Through magic of data rocessing, instant inventories of blood are available, and virtually no units are lost by expiration. MSMA Committee on Blood had dea in 1968, but lack of local interest and funding difficulties ave prevented implementation.


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the night shift of depression... insomnia

epression is a 24-hour-a-day problem. And insomnia is ften its nocturnal expression. In fact, insomnia may be a ey symptom in establishing the diagnosis of depression.

LAVIL HCl (Amitriptyline HCl, MSD) may prove quite elpful when you have arrived at such a diagnosis. Unlike sychic energizers or agents that merely elevate mood, LAVIL HCl embodies a mild antianxiety action which anifests itself even before the fundamental antidepressant ctivity of the drug becomes evident. Daytime drowsiness ccurs in some patients, usually within the first few ays of therapy.

OTE: Not recommended during the acute recovery phase ollowing myocardial infarction. Patients with cardiovascular isorders should be watched closely; arrhythmias, sinus achycardia, and prolongation of the conduction time have een reported, particularly with high doses; myocardial nfarction and stroke have been reported with drugs of this lass. Close supervision is required for hyperthyroid atients or those receiving thyroid medication. Concurrent lectroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is ssential. Discontinue the drug several days before elective urgery if possible.

Contraindications: Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exaggerated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, and 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives.

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Texas Plans Cancer and Environment Program

The University of Texas M. D. Anderson Hospital and Tumor Institute and the Texas Medical Center will sponsor "Environment and Cancer," the 24th annual Symposium on Fundamental Cancer Research, on March 3-5.

Co-sponsors are the University of Texas School of Public Health and the Graduate School of Biomedical Sciences, the American Cancer Society Texas Division, and the National Cancer Institute.

Chairman is Dr. Roger R. Hewitt, associate professor of biology, University of Texas at Houston, and vice chairman is Dr. Marvin M. Romsdalh, associate professor of surgery.

Registration is set for March 2 from 2-9 p.m. in the foyer of the Grand Ballroom of the Shamrock Hilton Hotel.

The registration fee is $5.00 and checks should be made payable to the University of Texas and mailed to Symposium Registration, the University of Texas, M. D. Anderson Hospital and Tumor Clinic, Houston, Texas 77025.

Dr. Jesse Steinfeld, U. S. Surgeon General, will deliver the keynote address on March 3 at 8:50 a.m. His topic is detecting and eradicating hazards in our environment.

ACP Sets March Oncology Program

The American College of Physicians will present Advances in Medical Oncology March 8-12, 1971, at the University of Texas M. D. Anderson Hospital and Tumor Institute, Houston, Texas.

The meeting place will be the Shamrock-Hilton Hotel, S. Main and Holcombe, Houston. Co-directors of the course are Drs. Emil Frei, III, and Charles A. Coltman.

Fee for ACP members and Fellows is $80, for nonmembers, $125, candidate members, $40, and residents and interns in training who are not candidate members, $80. The course must have no less than 50 and no more than 450 registrants.

This program will develop an approach to management built on a theoretical background in experimental therapeutics, pharmacology, cell population kinetics and immunology. The clinical application of basic concepts will be detailed through the use of new agents, combination chemotherapy, adjuvant chemotherapy and immunotherapy.

Brief Summary of Prescribing Information– 9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
February 1971, Vol. XII, No. 2

ORIGINAL PAPERS

The Surgical Treatment of Coronary Artery Disease

HILARY H. TIMMIS, M.D. and
JAMES D. HARDY, M.D.
Jackson, Mississippi

Surgery has played a progressively larger role in the management of coronary artery disease. The authors point out that prevention is the ultimate answer to this dilemma of the middle-aged male, but when surgery becomes necessary, there are a number of possible operative interventions. In this context, they discuss direct coronary artery reconstruction, carotid sinus stimulation, mitral valve replacement, myomectomy and others.

THE ROLE OF SURGERY in the management of dysfunction caused by coronary artery disease has broadened steadily and is highlighted today by direct coronary artery reconstruction of any or all of the major coronary vessels.[1, 2] While this procedure is most widely applicable to alter the natural history of the established defect, correction of factors predisposing to and producing coronary atherosclerosis must not be minimized.[3] Prevention alone provides the ultimate answer to this enormous drain of our greatest natural resource, the fruitful and productive middle-aged male. When surgery becomes necessary, however, direct revascularization is but one of a spectrum of operations which are available to the patient incapacitated with coronary artery disease.[4] In the foregoing discussion, this and other forms of operative intervention will be presented briefly.

From a surgical standpoint, coronary heart disease manifests itself mainly in four ways. First, by chest pain or angina pectoris which, in reality, is simply myocardial claudication secondary to either continuous or temporary ischemia during a period of increased cardiac work and myocardial oxygen demand; second, by a progressive, chronic reduction of cardiac output primarily due to reduced propulsive force of the ventricular myocardium or because of the increased work load presented by mitral incompetence; third, by conduction disturbances of which second and third degree heart block, premature ventricular activity and paroxysmal ventricular tachyarrhythmias are common examples; and fourth, by cardiogenic shock resulting from infarction of the ventricular wall, septum and/or papillary musculature. The surgical armamentarium, as it is directed primarily to the management of one or

From the Department of Surgery, University of Mississippi School of Medicine, Jackson, Miss.

more of these four manifestations, accommodates itself to an orderly review.

Intractable or Incapacitating Angina Pectoris. An objective evaluation of angina pectoris has always been hampered by the characteristic multiplicity of symptomatic patterns on one hand and the variable measure of psychic responsiveness on the other. However, with the advent of coronary angiography which permits precise mapping of the macroscopic coronary arterial tree to a vessel diameter of 200 microns, this symptom complex can now be evaluated much more precisely. In fact, approximately one-half of patients who are referred for evaluation of suspected coronary artery disease because of chest pain, prove to have a grossly normal coronary arterial tree.[5]

While there is some dissent concerning the validity of angina alone as a surgical indication, operative intervention has been advocated by internationally prominent cardiologists for those few patients with proved coronary atherosclerosis who simply cannot be controlled with nitrates, propranolol or related drugs.[6] Virtually any operation will provide at least temporary relief of anginal chest pain because of its complex emotional component. However, three procedures which are currently in use have some rational basis for a lasting effect.

a) **Carotid sinus stimulation.** It has been known for years that manual stimulation of the carotid sinuses can relieve angina pectoris by reflex vasodilatation and slowing of the cardiac rate which results in an overall reduction of ventricular work.[7] Electrical stimulation of the carotid sinus nerve will also produce the same effect and a device which provides this action is now available commercially.* In essence, the unit consists of an external transmitter antenna coil, and an implantable receiver with electrodes that are attached to the carotid sinus nerves (Figure 1). The apparatus is activated when increased cardiac demands are anticipated.

b) **Thoracic sympathetic neurectomy.** This procedure has continued to enjoy sporadic popularity for the symptomatic relief of angina pectoris. The operation which evolved during the past 20 years now consists of excision of the upper five thoracic sympathetic ganglia on the side of greater radiation of anginal pain.[8] Recently performed as a secondary operation, it has permitted direct electromagnetic measurement of

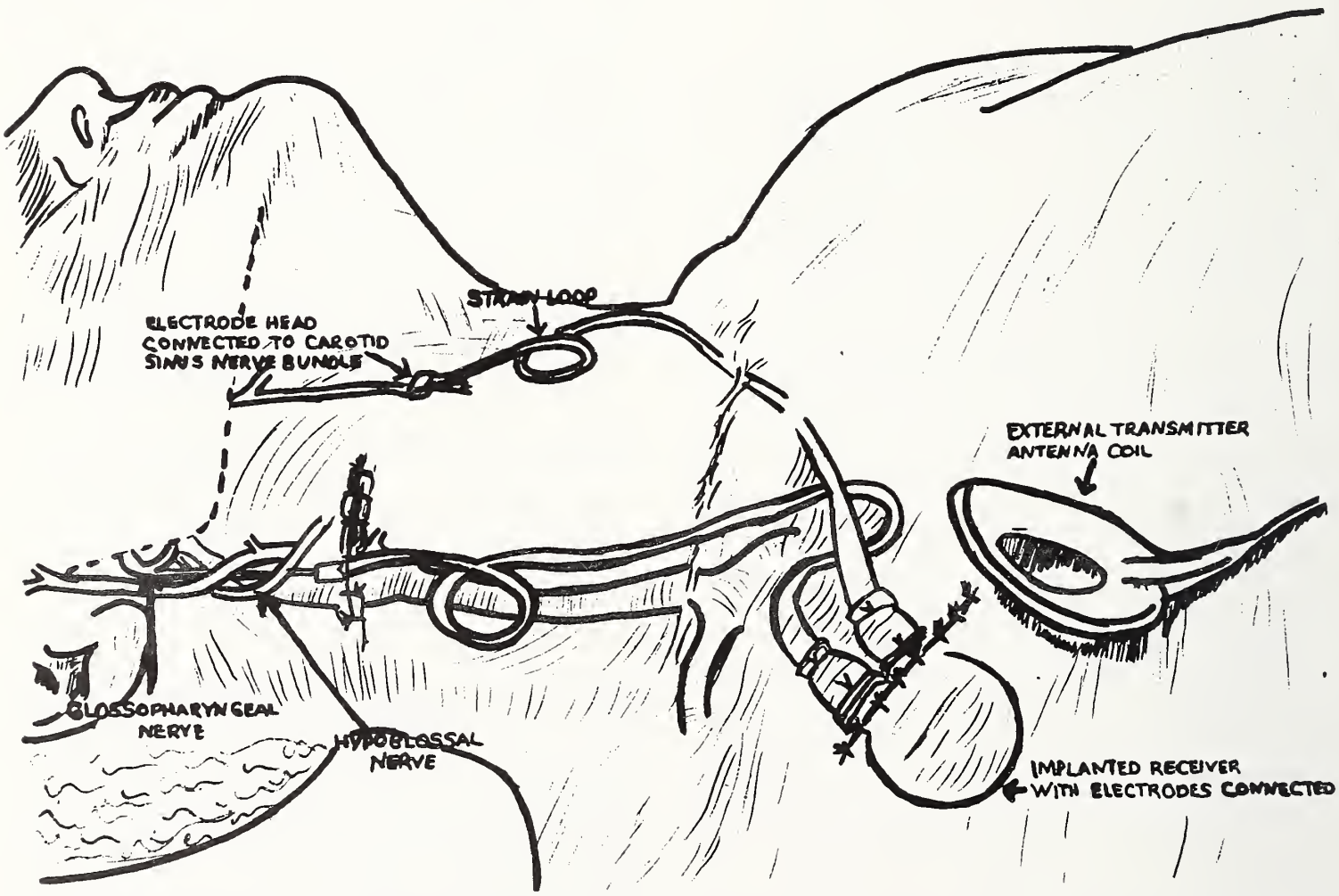


Figure 1. The reduction of ventricular work by reflex vasodilatation and bradycardia during electrical stimulation of the carotid sinus nerves can effectively reduce anginal chest pain.

flow delivered to the myocardium by internal mammary artery implants and allowed correlation with simultaneous coronary angiograms. In each instance, angiographic estimation of flow was greatly excessive, confirming our own experimental data.

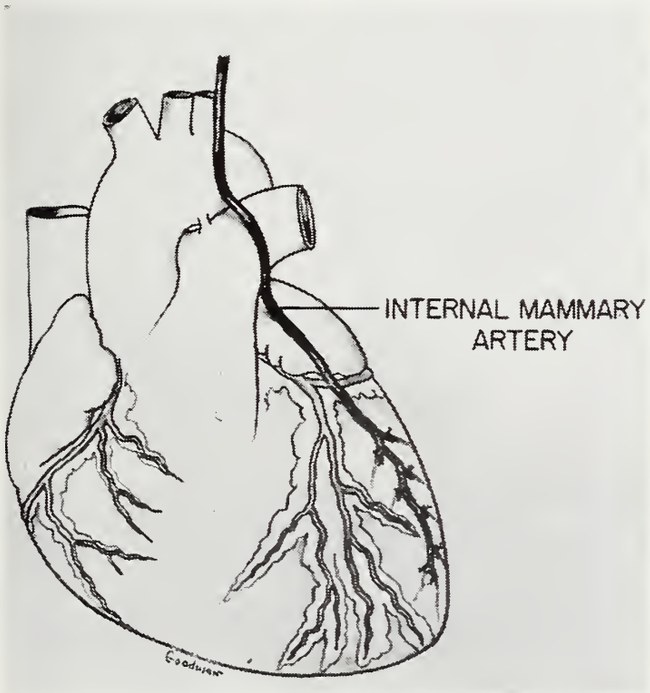


Figure 2. Indirect myocardial revascularization by multiple implantations of internal mammary intercostal branches will supply flow to areas deprived by diffuse obstructive coronary atherosclerosis.

c) **Internal mammary artery implantation.** The insertion of bleeding arterial vessels into the myocardial syncytium often provides effective symptomatic improvement when more definitive measures are contraindicated or impossible. The procedure which was first described by Vineberg in 1946 has also changed somewhat so that now multiple implantations of internal mammary artery branches are implanted into short left ventricular myocardial tunnels (Figure 2) rather than the classical single implantation of the entire internal mammary artery. While flow seldom reaches above 30 cc per minute, this quantity is apparently sufficient in many cases to afford symptomatic relief of anginal pain. On the other hand, there is not a single documented instance of measurable improvement of left ventricular function characterized by a postoperative elevation of cardiac output and reduction of left ventricular end-diastolic pressure.

Case Presentation 1. J. W., a 48-year-old accountant, was admitted to the University Hospital complaining of incapacitating chest pain with mild activity, only partially and erratically relieved by rest and sublingual nitroglycerine. The addition of Isordil 30 mg daily did not materially alter his symptoms. Diffuse narrowing and complete occlusion of the right coronary artery and partial occlusion of the anterior descending and circumflex arteries were demonstrated by coronary angiography. The left ventricular end-diastolic pressure was normal. On Dec. 10, 1969, the right internal mammary artery was implanted into the anterior wall of the left ventricle and the left internal mammary into the posterior wall. A seropericardiectomy was also performed (Figure 3). His postoperative course was uneventful and, as expected, his anginal symptoms were relieved immediately. However, he has since resumed full activity with virtually no use of nitroglycerine. He walks or jogs at least two miles daily, adheres strictly to a low fat diet, and continues to take Isordil 30 mg per day.

Reduced Cardiac Output. Surgical procedures for this problem are directed to reconstruction of cardiac anatomy, restoration of coronary blood flow, correction of mitral valve regurgitation, and removal of abnormally functioning or non-functioning ventricular myocardium.

Direct Revascularization. Efforts to improve coronary circulation by angioplastic procedures on the major coronary vessels are by no means new and, in fact, have been performed sporadically almost since the beginning of open heart surgery. Early procedures consisted mainly of endarterectomy and the use of patch grafts to widen partially occluded segments of diseased coronary arteries. These procedures were complicated by a high incidence of early failure due to the character of coronary atherosclerotic lesions which are commonly multiple in a single vessel. Endarterectomy was complicated by occlusion of side branches (the snow-plow effect) during removal of the atherosclerotic intima, whereas, simple patch grafts commonly had to be so lengthy as to render the procedure cumbersome and ineffective. The solution was provided brilliantly by autogenous vein grafts to bypass coronary artery lesions and introduce new flow directly from the aorta. The first successful procedures were performed in the Spring of 1967 and are now commonly employed throughout the country with a high incidence of success. The operation (direct myocardial revascularization) is particularly advantageous in that flow is supplied to a deprived myocardium immediately so that reduced function on the basis of myocardial ischemia is rapidly corrected. Consequently, patients in heart failure receive benefit when it is most urgently needed to survive the

surgical procedure itself. Single, double, and triple bypass grafts can be performed to the relatively normal distal major coronary arteries with the expectation of long-term patency even though one is dealing with vessel diameters as small as 1 mm (Figure 4).

Two technical demands of this operation which must be met for consistent success include a long distal anastomosis which functions in essence like a patch graft across one or more stenotic or occluded areas, and meticulous care in placing sutures at both angles of the distal anastomosis to avoid compromise of the coronary artery lumen. Utilizing suture material of 6-0 caliber or smaller, these suture lines can be constructed easily with some practice. Although cardiopulmonary bypass is recommended for revascularization procedures on branches of the left coronary artery, those on the right coronary artery can be performed with safety in the beating heart if the vessel is completely occluded proximally.

Case Presentation 2. E. P., a 54-year-old housewife, was admitted for evaluation of incapacitating chest pain and severe exercise limitation. A clinical diagnosis of angina pectoris due to coronary heart disease was supported by electrocardiographic evidence of myocardial ischemia. A declining response to long and short acting nitrates prompted cardiac catheterization and coronary angiography. Left ventricular end-diastolic pressure was normal and the kinetics of the left



Figure 3. The mobilized left internal mammary artery is shown where it enters the left ventricular myocardium.

ventricle were satisfactory. The anterior descending artery was totally occluded proximally and multiple stenotic areas were present in the distal vessel (Figure 5a).

Direct revascularization was performed on June 10, 1970, with a saphenous vein bypass graft from aorta to the distal anterior descending artery. Her postoperative course was unremarkable except for refractory atrial fibrillation which was controlled with digitalis and quinidine. Subsequent coronary angiography confirmed graft patency (Figure 5b). She has enjoyed a very satisfactory functional recovery and complete relief of anginal pain.

Mitral Valve Replacement. Progressive enlargement of the left ventricle occasionally results in dilatation of the mitral valve annulus and significant mitral regurgitation. In this instance, mitral valvuloplasty alone or in combination with direct revascularization can restore satisfactory function to a decompensating heart. More commonly, mitral insufficiency results from papillary muscle dysfunction due to an alteration of the papillary muscle blood supply and in some in-



Figure 4. The saphenous vein bypass is shown transversing the pulmonary outflow tract as it carried blood from the aorta to the anterior descending artery.

stances appears acutely following infarction and rupture of a papillary muscle.[9] Here the florid heart failure which ensues may be reversed only by mitral valve replacement. If the operation is performed before there is significant compromise of the myocardium itself, the results can be dramatic.

Case Presentation 3. J. H., a 35-year-old veteran, was referred to the University Hospital for evaluation of coronary artery disease and severe hyper-cholesteremia complicated by anterior myocardial infarction two years previously, subsequent papillary muscle dysfunction with mitral regurgitation and finally, refractory congestive heart failure. Cardiac catheterization and angiocardiography confirmed the presence of moderate



Figure 5a. The anterior descending branch of the left coronary is completely occluded proximally and has multiple points of stenosis faintly demonstrated distally.

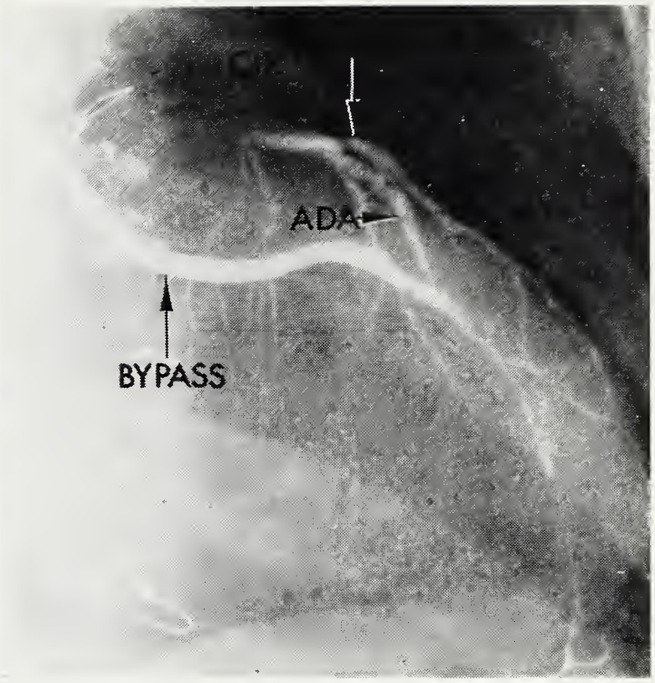


Figure 5b. Both antegrade and retrograde flow were restored by saphenous vein bypass from the aorta to the distal anterior descending artery.

mitral insufficiency, left atrial and pulmonary hypertension and atherosclerotic disease of the circumflex and right coronary arteries. Mitral valve repair was recommended because of the intractable character of his symptoms. The ruptured anterior papillary muscle was easily identified at operation (Figure 6) and since the mitral leaflets themselves were severely attenuated, a prosthetic valve was used for replacement. His postoperative course was unremarkable and he was discharged two weeks later with marked improvement of exertional dyspnea and orthopnea. However, he was subsequently admitted to the Veterans Administration Hospital with progression of coronary artery disease and eventually expired.

Myomectomy. While the heart has an enormous capacity to develop collateral channels during a gradual deprivation of coronary blood flow, sudden reduction of blood supply to discrete areas of the left ventricular myocardium can cripple cardiac performance. Marginal myocardial viability ultimately results in patchy fibrosis whereas partial or transmural infarction is eventually replaced with scar tissue. In either case, the acute loss of participation of a segment of the ventricular wall in cardiac contraction can result in cardiogenic shock on one hand or chronic congestive failure on the other. Furthermore, since non-contractile myocardium has little compliance, it may actually move paradoxically during systole and further compromise cardiac function by acting as a depulsating chamber which receives part of the stroke volume. This phenomenon was recognized in ventricular aneurysms years ago and ventricular aneurysmectomy constituted one of the first cardiac surgical procedures.

More recently, attention has been directed to dyskinetic or akinetic myocardium which is simply not participating in effective myocardial contraction and excision of these segments of the left ventricle which was suggested by Murray in 1946 and pioneered experimentally by Heimbecker in 1967 has resulted in some dramatic survivals.[10, 11] Cardiopulmonary bypass is required and can be instituted quickly and simply, in the patient's room if necessary. Once started, the circulatory load is immediately removed from the failing ventricles. It then remains for the surgeon to reconstruct altered anatomy, restore valve competency, and/or if possible, reestablish blood supply to deprived myocardium.

Repair of Ruptured Septum. Acquired ventricular septal defect most commonly results from infarction and rupture of the ventricular septum anteriorly and near the cardiac apex due to occlusion of the anterior descending branch of the left coronary artery. The hemodynamic load resulting from the sudden presence of a left to right shunt may precipitate cardiogenic shock and rapid demise. Characteristically, the patient's circulatory

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and the Latin **sedatus,**
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status suddenly worsens and a harsh precordial systolic murmur becomes evident several days after infarction when necrotic tissue tensile strength is at a minimum. If a lesion appears to be reasonably well tolerated, it is best to defer surgical correction to permit some organization of the edges of the defect and hence increase their capacity to hold sutures. There are two reported instances where this procedure was successfully combined with infarctectomy in the region of the left ventricular apex.[12, 13]

Case Presentation 4. J. W., a 48-year-old veteran was transferred to the University Hospital for emergency cardiac catheterization following the sudden onset of a harsh precordial murmur and peripheral vascular collapse while convalescing from a recent myocardial infarction. Two episodes of ventricular fibrillation were reversed during the procedure which confirmed the presence of a ventricular septal defect and hemodynamic failure. He was immediately moved to the operating room where during cardiopulmonary bypass, a 5 cm infarct of the left ventricular wall and an apical septal defect were identified. The former was excised and both lesions repaired as shown in Figure 7. His early postoperative course was characterized by a steady improvement of cardiac function although he was troubled initially with recurrent ventricular tachyarrhythmias. One month later he sustained another episode of transient collapse, probably due to pulmonary embolism from which he recovered completely. He has since remarried and is free of symptoms.



Figure 6. A ruptured papillary muscle is visualized through the left atrium during cardiopulmonary bypass. Valve replacement with a valve prosthesis was performed.

Surgical Management of Ventricular Arrhythmias. In about 10-15 per cent of patients, acute myocardial infarction will produce second or third degree heart block with slowing of the cardiac rate to a point that temporary artificial pacing becomes necessary. This adjunct can now be established easily by the transvenous insertion of a bipolar endocardial electrode. In most instances, especially with posterior infarcts, spontaneous recovery of a sinus mechanism will occur within two weeks and no further treatment is necessary. However, approximately 20 per cent will have persistent conduction disturbances which require more permanent measures. The development of a transvenous technique to establish permanent artificial pacing in these patients is a major breakthrough which has been used successfully here and elsewhere for several years. The procedure is extremely well tolerated in that it can be performed under local anesthesia, eliminating the necessity of a major thoracotomy and manipulation of the heart itself. We generally use the right external jugular vein as a conduit for the endocardial electrode and utilize a subpectoral or suprapectoral pouch for the pulse generator (Figure 8). More recently, the development of a demand pacing system which is active only when needed accommodates itself well to those patients in whom spontaneous recovery of a sinus mechanism may occur weeks or months later. Here the artificial pacing automatically stops, but the pacemaker sensing device remains active in the event that heart block should ensue at a later time.

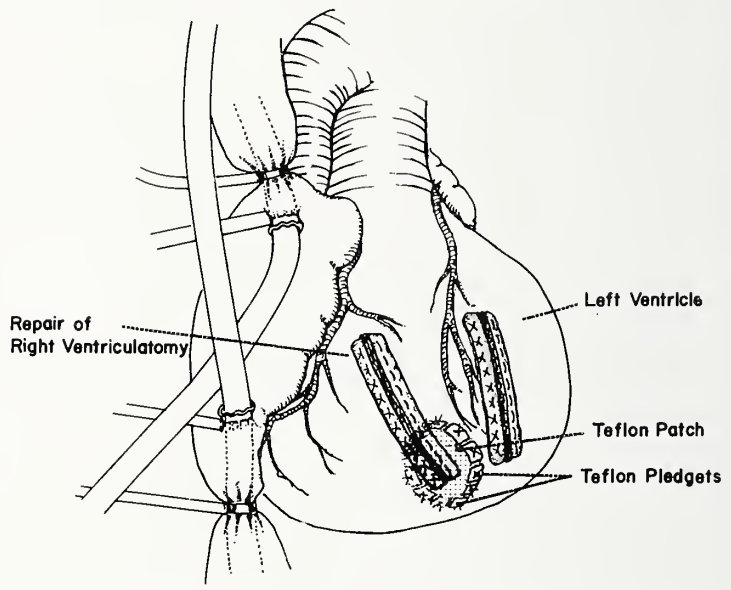


Figure 7. Excision and repair of a 5 cm left ventricular infarct and closure of a large apical septal defect produced lasting restoration of cardiac function.

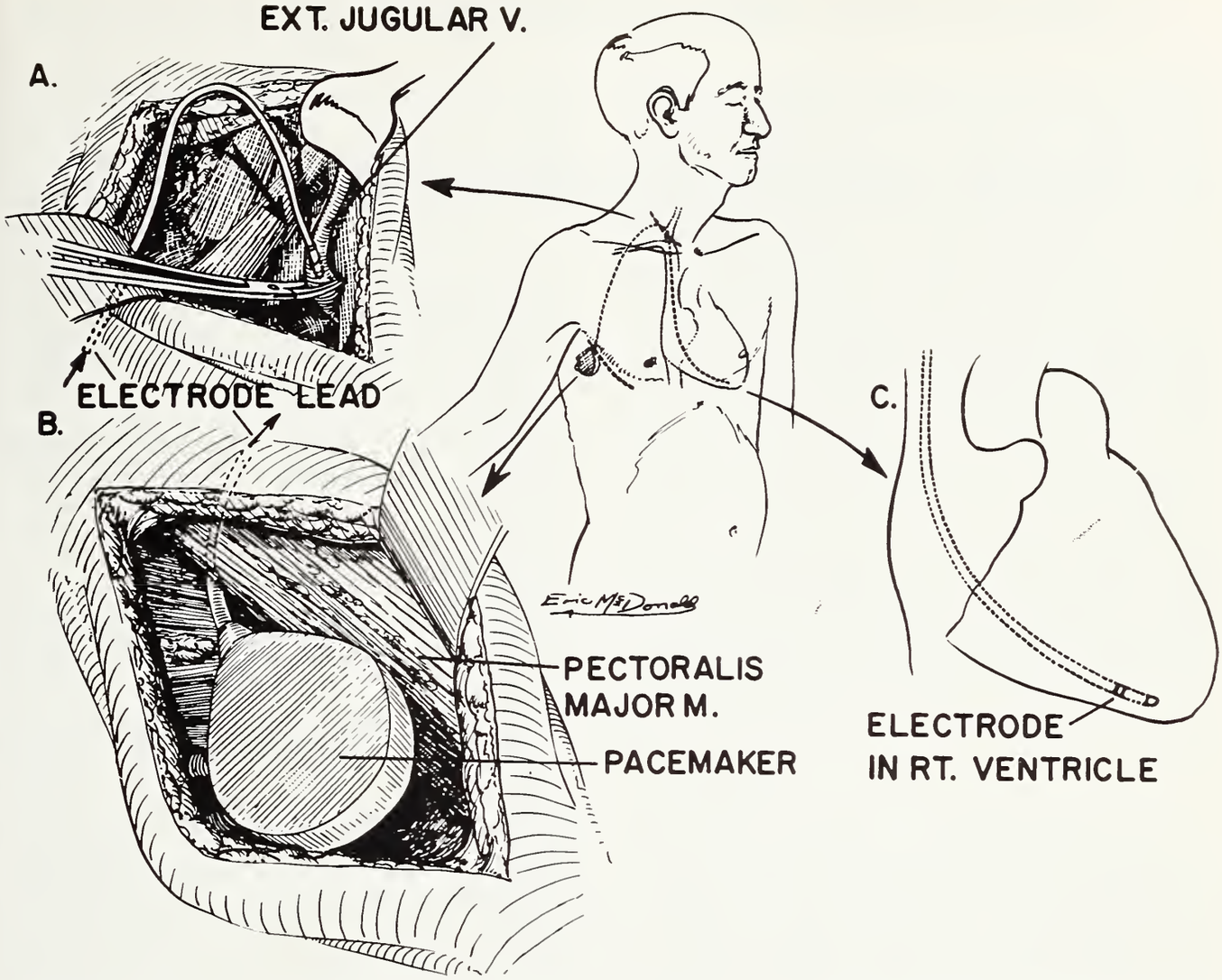


Figure 8. Permanent cardiac pacing can be established with minimal trauma under local anesthesia by the transvenous route. The pulse generator is implanted in the pectoral region and is readily available for subsequent replacement.

When ventricular irritability as manifested by severe premature ventricular activity or episodes of ventricular tachycardia remains a problem after apparent healing of a myocardial infarction, permanent pacing with a fixed rate unit is occasionally successful in suppressing the arrhythmia. In our experience, approximately 50 per cent of patients will be controlled with this adjunct, whereas, the remainder are captured by the artificial pacing system only periodically and continue to have bursts of ventricular activity.

Case Presentation 5. F. W., a 65-year-old man, began to have Adams-Stokes attacks and bouts of pulmonary edema about one week following a well documented myocardial infarction. Temporary pacing was initiated with satisfactory control of his cardiac rhythm. During a two week period of observation, he failed to regain a persistent sinus mechanism. Permanent pacing was then established with a bipolar endocardial electrode and subpectoral pulse generator, implanted under local anesthesia. His convalescence was unremarkable and several months later, episodes of heart block spontaneously resolved. Subsequently, artificial pacing was discontinued.

Left Ventricular Augmentation. Finally, when cardiogenic shock complicates coronary occlusion, the likelihood of survival is markedly reduced. Cardiac performance, which is severely compromised by the initial insult, is progressively worsened by the shock-like status itself which produces progressive peripheral stasis and underperfusion, hypoxemia, lactic acidosis, and eventually irreversible peripheral vascular collapse. In some instances, this series of morbid events can be reversed by providing mechanical support ei-

ther to remove the circulatory load from the left ventricle or to distribute it in a way throughout the cardiac cycle that it is more efficiently handled. The three primary techniques include: first, arterio-arterial bypass in which arterial blood is removed during systole to reduce ventricular stroke work and returned to the arterial vascular tree during diastole when the heart is quiescent; second, left atrial-arterial bypass in which pulmonary venous return is removed by way of a transseptal intra-atrial catheter and returned into the distal arterial tree; and third, intra-aortic balloon pumping in which arterial blood volume is moved during diastole by the precisely timed, rapid inflation of a large intra-aortic balloon which is synchronized with the electrocardiogram. In each instance, the overall result is a more effective arterial circulation, enhanced coronary blood flow and reduction of cardiac work. The theory of ventricular augmentation is sound and survival rate is improving yearly as more patients who have not entered irreversible shock are being treated.

SUMMARY

The foregoing discussion touches briefly upon the surgical procedures which are designed to afford palliative or permanent relief of the ubiquitous manifestations of coronary heart disease. The most exciting of these is direct coronary artery reconstruction by saphenous vein bypass graft which immediately increases coronary blood flow to the deprived areas, relieves the symptoms and dysfunction due to myocardial ischemia and restores cardiac invalids to a normal active life. The ultimate goal of therapy must remain first and foremost, that of prevention. There are undoubtedly many factors, many of which are probably preventable, that potentiate or produce coronary atherosclerosis.

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* Angiostat, Medtronic Corporation, Minneapolis, Minnesota.

Aided by USPHS Grant No. HE-06163-04 and American Heart Association Grant No. 68-853.

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Respiratory Distress in the Newborn

JOHN E. RAWSON, M.D.
Jackson, Mississippi

Respiratory distress is one of the most common abnormal clinical findings in the newborn infant, and it is important that it be recognized and treated immediately. The author discusses infants who are at greater risk for developing respiratory distress than others and diagnosis of the disease entities which produce it. He evaluates respiratory distress and describes various etiologies including pneumonia, pneumothorax, congenital problems and transient tachypnea. An outline to the therapeutic approach is also given.

RESPIRATORY DISTRESS is one of the most common abnormal clinical findings in the newborn infant. Since respiratory distress, from whatever cause, may reduce the available oxygen supply to the infant's brain, immediate recognition by both the nurse and physician is required so that steps can be taken to accurately diagnose and adequately treat the condition causing the respiratory distress. Thus, the immediate handling of the condition causing the respiratory distress may materially reduce both the number of infants dying from asphyxia, as well as reduce the number of infants surviving with central nervous system damage.

Since various disease processes in the newborn infant may be manifest in ways different from older children or adults, an important first step in handling newborns is the recognition of abnormal clinical states. Respiratory distress is defined as "difficult breathing." The most common manifestations of respiratory distress in the newborn are apnea (no respiratory effort for greater than 20 seconds); tachypnea (respiratory rate greater than 60 times per minute); costal and sternal retractions; flaring of the alae nasi and expiratory grunting. Cyanosis may also be present in some infants. In moribund infants, gasping respirations are frequently seen.

Certain infants are at much greater risk for developing respiratory distress than others. In general, respiratory distress is seen much more commonly in premature infants than in full-term infants. In both full-term and premature infants, the likelihood of developing respiratory distress is greatest in the first three days of life, usually in the first eight hours of life. There are numerous maternal conditions which may result in altered fetal physiology eventually leading to the development of respiratory difficulties in the newborn infant. A list of these maternal conditions is given in Table I. A common denominator in all these conditions relates to either production of intrauterine asphyxia or respiratory depression of the infant at birth. There are two main ways that intrauterine asphyxia may predispose to respiratory difficulties in the newborn infant. In the preterm fetus, the pulmonary cells which produce surfactant and keep the lung expanded after the first breath have been shown to be damaged during even mild intrauterine asphyxia. Although the pathogenesis for clinical hyaline membrane disease (HMD) is not fully understood, a potential initiating factor, asphyxia, could arise from almost any one of the conditions listed in Table I.

From the Department of Pediatrics, University of Mississippi School of Medicine, Jackson, Miss.

The second way that intrauterine asphyxia may predispose an infant to the eventual development of respiratory distress relates to the frequent passage of meconium by the fetus as well as the initiation of fetal gasping. It is not known why the fetus passes meconium in response to asphyxia. The fetal gasping results from the stimulation of the respiratory center in the brain stem by the elevated PCO_2 that develops during the asphyxia. As will be pointed out later, amniotic fluid, especially when it contains meconium, is very irritating to the pulmonary parenchyma and produces a chemical pneumonitis.

Other factors which occur postnatally are also known to predispose the infant to the development of respiratory disease such as hypothermia, use of positive pressure ventilation and nebulization, especially when improper cleaning techniques involving both personnel and equipment are employed.

TABLE I

OBSTETRICAL CONDITIONS INCREASING RISK OF RESPIRATORY DISTRESS*

I. Premature delivery
II. Mechanical factors
  A. Cephalopelvic disproportion or shoulder dystocia
  B. Malposition of infant
  C. Abnormal uterine contractions
  D. Prolapse of umbilical cord or other causes of cord compression
  E. Multiple pregnancy
  F. Difficult forceps delivery
III. Maternal hemorrhage
  A. Abruptio placentae
  B. Placenta previa
  C. Other antepartum hemorrhage
IV. Other maternal conditions
  A. Maternal age >35 years or <19 years
  B. Grand multiparity
  C. Toxemia of pregnancy or preeclampsia
  D. Diabetes mellitus
  E. Cardiorespiratory disease
  F. Ruptured BOW's with amnionitis
  G. Prolonged labor
V. Iatrogenic factors
  A. Excessive maternal analgesia
  B. Excessive maternal anesthesia
  C. Antihypertensive agents
  D. Maternal hyperventilation

* Adapted from Avery: Lung Disease in the Newborn, 2nd edition. Saunders.

The disease entities which produce respiratory distress are listed in Table II. Those entities which are more commonly seen or which require rapid recognition and treatment will be discussed. The conditions resulting in the largest amount of illness and death in the nursery are hyaline membrane disease, bacterial pneumonia and meconium aspiration.

HMD

Respiratory distress which begins under eight hours on a premature infant is most likely clinical hyaline membrane disease (HMD). This entity is thought to be caused by lack of surfactant in the infant's lungs. This material begins to appear in lung tissue at about 28 weeks' gestation. In the preterm developing fetus, the cells which produce this material are easily damaged by hypoxia from any cause mentioned previously. When surfactant is not present, the alveolae collapse at the end of expiration. The resulting lung is diffusely atelectatic with poor diffusion properties. Some of the conditions that may produce intrauterine hypoxia are listed in Table I.

The diagnosis of HMD is made with the aid of the following criteria: 1) respiratory distress, as previously described, in a premature infant less than eight hours old, manifested by tachypnea, flaring of the alae nasi, grunting and retraction of chest; 2) a mixed metabolic and respiratory acidosis (elevated PCO_2 and a pH which is lower than one would expect for the degree of CO_2 retention); 3) hypoxia (a low PO_2 on 100 per cent oxygen); and 4) an x-ray showing diffuse atelectasis (a homogenous ground glass appearance to the lung fields with air bronchograms being seen when there is sufficient atelectasis). The severity of the disease can be determined from the following studies: Biochemical evidence of severe disease is a PO_2 of less than 100 mm Hg in 100 per cent O_2 or a PCO_2 of greater than 70 mm Hg. The severity of the disease can also be graded by the x-rays as outlined in Table IV.

The other clinical findings of these infants are dry scratching "to and fro" breath sounds; edema (which is hard to appreciate on the first day because of its non-pitting nature) and congestive heart failure (which is manifested by a tachycardia greater than 160 beats per minute and progressive enlargement of the liver).

Infants who are going to survive usually improve by the second or third day. They show a decrease in respiratory rate with a lessening of retractions and loss of the flaring and grunting. There is usually a diuresis associated with this decrease in respiratory distress. Most of the infants

TABLE II

CAUSES OF RESPIRATORY DISTRESS

(Listed by usual age at the onset of symptoms)

I. Infants less than eight hours old
  1. Hyaline membrane disease
  2. Transient tachypnea of newborn
  3. Pulmonary arterial spasm syndrome
  4. Miscellaneous causes of transient tachypnea
    A. Hypothermia of infant
    B. Pneumomediastinum (air block)
    C. Non-tension pneumothorax
  5. Intrauterine pneumonia
  6. Sedation by maternal anesthesia or analgesia
  7. Magnesium intoxication (from maternal Mg. SO_4)
  8. Pulmonary hemorrhage
  9. Congenital heart disease especially
    A. Transposition of the great vessels
    B. Hypoplastic left heart syndrome
  10. Other congenital anomalies
    A. Choanal atresia
    B. Tracheal stenosis or atresia
    C. Laryngeal web
    D. Agenesis or hypoplasia of lungs
    E. Diaphragmatic hernia
II. Infants less than 24 hours old
  1. Tracheo-esophageal fistulae with associated esophageal atresia
III. Infants greater than 24 hours old
  1. Acquired pneumonia
  2. Intrauterine pneumonia (infant less than three days old)
  3. Congenital heart disease
    A. Large ventricular septal defect
    B. Truncus arteriosus
    C. Total anomalous venous return
    D. Anterovenous coral
    E. Severe aortic stenosis
    F. Severe pulmonary stenosis or atresia
    G. Patent ductus arteriosus
  4. Other congenital anomalies
    A. Tracheomalacia
    B. Malformation of the great vessels
    C. Mediastinal masses
IV. Conditions which may be seen at any age
  1. Tension pneumothorax

with grade 1 x-ray changes will do well with some supplemental oxygen and intravenous Usher's solution. The infants with grades 2 and 3 x-rays will have a more rocky course. The disease usually peaks at 48 to 72 hours. If the infant can continue to expend enough energy to hyperventilate while the metabolic acidosis is being corrected with buffer, the hypoxia is being corrected with supplemental oxygen and calories are being given IV, he will improve as his lungs begin to return to normal.

Many infants simply wear out on the second or third day and die of respiratory failure. Some of these infants can be saved with artificial ventilation. Infants with grade 4 x-ray changes usually die within 24 hours even when treated with artificial ventilation. Infants with pulmonary hemorrhage are prematures who appear to have severe HMD and usually die within 24 hours. This process is apparent from the appearance of copious amounts of relatively pure blood coming from the air passages.

In addition to the progressive respiratory distress ending in apnea, there are two other fairly frequent causes of death in patients with HMD. Intracranial hemorrhage usually becomes clinically apparent with an episode of apnea and/or cyanosis in an infant who was handling his respiratory distress reasonably well. The sudden onset of pulmonary hemorrhage in an infant who seemed to be improving is the other catastrophic event leading to death. There is progressive deterioration of the infant in spite of adequate supportive therapy. The occurrence of these hemorrhagic phenomena is not apparently related to the severity of the disease and there is no known prevention or therapy at this time.

ASPIRATION SYNDROMES

Intrauterine or paranatal aspiration of amniotic fluid, meconium or other debris may result in respiratory distress from a chemical pneumonitis or a mechanical blockage of some of the smaller airways. In an earlier section of this paper, intrauterine hypoxia with its resultant passage of meconium into the amniotic fluid and the initiation of gasping was discussed. Any time there is aspiration of particulate material, a partial blockage of the airways can result in over-expansion of the lung tissue distal to the blockage or if a complete block exists, atelectasis will ensue. This results in a maldistribution of the inhaled gases and decreases the efficiency of the lung especially as to oxygenation.

The inhalation of the normal amniotic fluid *in utero* may produce some respiratory problems but this point has not been firmly settled yet. There is particulate material such as squamous cells and hair in amniotic fluid and this material has been found in the lungs of infants at autopsy who have died of severe respiratory distress following intrauterine hypoxia; but this material has also been found in lungs of infants who died of causes other than pulmonary diseases. This entity is called massive aspiration syndrome. If the amniotic fluid is infected, its aspiration will lead to an intrauterine pneumonia.

The aspiration of meconium containing amni-

otic fluid results in a chemical pneumonitis usually of a very severe degree. Clinically these infants are tachypneic and usually have less retractions than infants with HMD. Rales are normally heard during the first few minutes of life but may continue to be heard in these infants for hours. Cyanosis is common and may respond poorly to the administration of oxygen. Blood gases show low PO_2 on 100 per cent oxygen with normal or slightly low PCO_2 and usually a metabolic acidosis from hypoxia. High and rising PCO_2 is associated with severe disease and is a bad prognostic sign. The x-rays show coarse "honeycomb" central infiltration which resembles a sunburst around the cardiac shadow. Later films may show hyperexpansion of some or all of the lung parenchyma from air trapping.

The usual course of the disease is for those infants who will die to do so within 24 hours and those who will survive to be better in 72 hours but they continue to be tachypneic for many days or even weeks. This condition should be suspected any time meconium stained fluid is present at birth. Direct visualization of the larynx with a laryngoscope will show if meconium is present in the hypopharynx or upper trachea. When it is seen, the meconium should be removed by suction and saline lavage of the trachea. If a positive pressure face mask is applied before this material has been removed, it will be driven further into the periphery of the lung, producing a more severe pneumonitis.

PNEUMONIA

Pneumonia may be seen at any age in the newborn infant. The infection can be acquired during intrauterine life, intrapartum life or postpartum life. Intrauterine or intrapartum acquisition of pneumonia should be considered highly likely when problems listed in Table III exist. Symptoms usually begin within the first 72 hours of life. The typical signs of pneumonia in the older infant or child such as tachypnea and elevated temperature are frequently not the presenting signs. Most frequently the neonate may present an irregular respiratory pattern with apnea and/or cyanosis. This terminal event is frequently preceded by signs of sepsis such as poor suck, lethargy and/or abnormalities in thermal regulation—usually hypothermia. Chest x-rays may initially look normal even in infants presenting with apnea who subsequently develop unequivocal pneumonia by x-ray. Subsequent films may show infiltrates in the perihilar or peripheral regions involving the lungs generally or any one lobe or segment of the lung.

The etiologic agents in pneumonias developing in the first 72 hours of life are *E. coli, Streptococcus* and *Staphylococcus*. The usual initial antibiotic therapy is penicillin or ampicillin in combination with kanamycin.

TABLE III

CONDITIONS INCREASING RISK OF AMNIONITIS

1. Rupture of membranes > 24 hours
2. Labor > 18 hours
3. Maternal temp > 100.6
4. Organism or polymorphonuclear cells on gastric aspirate
5. Purulent amniotic fluid

Postnatally acquired pneumonia can be seen in both full-term and premature infants. Infants requiring positive pressure or nebulization therapy should be considered at high risk for developing pneumonia. The signs and symptoms are similar to those listed for pneumonia acquired *in utero*. Etiologic agents involved in postnatally acquired pneumonia are primarily *Pseudomonas, Klebsiella-Aerobacter group* and *Staphylococcus*. One additional note regarding pneumonia in the premature infant should be considered. The infant who fails to gain weight at the expected rate should be carefully examined for infection. Pneumonia is a common cause of failure to gain weight. This growth retardation may be evident several days before there are signs or symptoms pointing to the respiratory system.

Pneumothorax is defined as air in the pleural cavity. Pneumothorax can occur at any age. It is most common in infants with aspiration pneumonitis or in infants who have required positive pressure ventilation. The most common presenting picture of a tension pneumothorax is the sudden onset of dyspnea, tachypnea with cyanosis, systemic hypoxia and shock. This clinical picture results from shift of mediastinal vascular structures with a marked decrease in venous return to the right side of the heart. Chest x-rays show the presence of free air in the pleural cavity. Treatment initially is removal of the air with a blunt needle on a syringe with a three-way stopcock. This may be life saving until chest tubes can be introduced into the pleural cavity and connected to underwater suction.

Some infants have the presence of free air in the pleural space which is not under tension. This is often from rupture of a subpleural bleb in infants with pneumo-mediastinum. This situation

results in tachypnea with little or no dyspnea. Blood gases may show mild alkalosis and a lowered PCO_2. The clinical course is one of improvement as the air is absorbed over the next 36 to 48 hours. No treatment is necessary.

Congenital anomalies of the respiratory tract and the cardiovascular system may produce respiratory distress. The entities discussed below were covered in more detail in the article on "Surgical Emergencies in the Newborn" (J.M.S.M.A. XI:585-593 (Nov.) 1970) in this series.

Congenital heart disease may produce respiratory distress in the newborn period. It is often difficult to distinguish between congenital heart disease and some of the previously mentioned pulmonary conditions causing respiratory distress, especially when the infant has cyanosis. The clinical finding or findings in association with respiratory distress, which may lead one to suspect congenital heart disease, are congestive heart failure, cardiomegaly by x-ray (C/T greater than 0.6) and abnormalities on ECG such as right or left ventricular hypertrophy or an arrhythmia. The earliest manifestation of congestive heart failure in the neonate may be either tachypnea (respiratory rate greater than 60 breaths per minute) or tachycardia (heart rate above 160 breaths per minute). Other findings are the most classical findings in the older child or adult, those being progressive enlargement of the heart and liver. Both peripheral and pulmonary edema with rales are late manifestations and in some patients may not appear at all. A more detailed discussion of congenital heart disease in neonates regarding both diagnosis and therapy will be presented in a forthcoming article in this series.

TABLE IV*

Grade 1
Minimal generalized increased density in lung parenchyma.
Air bronchograms do not extend to edge of cardiac shadow.
No cardiomegaly.
Grade 2
Easily discernible increase density in lung parenchyma.
Air bronchograms may extend to edge of cardiac shadow.
No cardiomegaly.
Grade 3
Obvious increase in density of lung parenchyma.
Air bronchograms extend beyond cardiac shadow.
Cardiac to thoracic ratio greater than 0.6.
Cardiac shadow distinguishable from lung tissue.
Grade 4
Opacified lung fields.
Cardiac shadow not discernible from lung parenchyma.

* Adapted from Martin-Bouyer, Symposium on Artificial Ventilation. Paris, 1969. in Biol. Neonate, Vol. 16:164-183.

Choanal atresia is lack of continuity between the nasal passages and the pharynx. This may be due to bony obstruction or a membrane. Since newborns are obligate nose breathers, this prevents breathing. It is diagnosed by the inability to pass a catheter through the nasal passages. The initial treatment is an oral airway or, if necessary, an endotracheal tube until definitive surgical correction can be done.

LARYNGEAL WEBS

Laryngeal webs are membranous obstructions which may be present at the level of the cords or just above or just below them. If the web is complete, the infant gasps for air but none enters the lung. Usually, the web is only partial and stridor, hoarseness or weak cry are the presenting symptoms. Perforation of a complete web or dilatation of a partial web is the initial life-saving therapy.

Tracheoesophageal fistulae are usually associated with esophageal atresia. These infants often require frequent suction in the first few hours of life because of accumulations of secretions in the hypopharynx. Polyhydramnios is frequently seen in most upper gastrointestinal obstructions. When these clues are present, a catheter should be passed and air instilled while listening over the stomach; if there is any doubt that the catheter reached the stomach, the study should be repeated using a radiopaque catheter and x-rays. When atresia is present, the catheter is seen coiled in the upper esophagus. When feedings are started, aspiration of formula into the lungs produces obvious respiratory distress associated with cough. The aspiration pneumonitis is treated as described previously in this paper. Surgical correction is required.

Congenital diaphragmatic hernia is a defect in the diaphragm usually on the left. The stomach and some of the intestines are in the left pleural cavity with displacement of the heart to the right and collapse of the lung. In the rare cases when the defect is on the right, the liver and the hepatic flexure of the colon are in the right pleural cavity with collapse of the lung. The clinical symptoms which make one suspect this diagnosis are respiratory distress beginning shortly after birth, a shift of the heart sounds to the right, scaphoid abdomen. Worsening of the situation may occur with the use of positive face mask ventilation because filling the stomach with air will further shift the mediastinum to the right. There may be decreased breath sounds over the left chest and

bowel sounds are sometimes heard in the left chest. X-rays show stomach and intestines in the left chest with collapse of the left lung. Treatment is surgical correction of the hernia and supportive therapy for the respiratory problems. Often the lung is hypoplastic and never fully re-expands.

TRANSIENT TACHYPNEA

Many infants in the nursery have tachypnea which fails to fall into one of the above defined categories, and their clinical course turns out to be benign. Transient tachypnea as a diagnosis is made by excluding other causes of tachypnea. Some of the causes of transient tachypnea will be discussed below.

There is a syndrome in full-term infants called transient tachypnea of the newborn. Respiratory rates may be up to 100 times per minute in some infants but flaring, grunting and retractions are not present. X-rays show prominent streaking with a cardiac shadow at the upper limits of normal; there may be flattening of the diaphragm. Blood gases are normal. The tachypnea and chest x-rays usually clear in three to seven days. Etiology is unclear but may represent delayed reabsorption of fetal lung fluid by the lymphatics or a mild interstitial edema in the pulmonary parenchyma.

Newborns have a mild metabolic and respiratory acidosis (low pH and elevated PCO_2) at birth from the hypoxia associated with a normal delivery. If infants who are otherwise normal are allowed to chill, there is a slower recovery from this acidosis than in infants who are kept warm. One of the responses to this is tachypnea. When an infant who already has a respiratory problem is chilled, it increases the severity of his already deranged metabolic state. Premature infants become hypothermic more readily than full-term infants and are more adversely affected by the low body temperature.

Pneumomediastinum is the presence of air in the retrosternal space and on occasions may extend to the middle mediastinum to outline the pericardium. A pseudonym for this entity is "air block." The symptoms are tachypnea usually with no dyspnea. X-rays show the air in the retrosternal space and sometimes around the pericardium. Blood gases may show a low PCO_2, normal oxygen and slight alkalosis. The clinical course is one of improvement over several days. The x-rays show a decrease in the amount of air in the mediastinum.

EARLY RECOGNITION

Early recognition of the presence of respiratory distress is important. A review of the age of the infant, the circumstances of delivery and the maternal history or the infant's previous history give one information on the type of problem to suspect. This information along with x-rays and blood gases (if available) are the most productive laboratory procedures. Table V outlines this material for the common problems encountered. X-rays should be obtained when tachypnea persists longer than two hours as this is the single most valuable diagnostic tool. The patient should be followed by x-rays especially to look for pneumothorax and the appearance or progression of infiltrative changes. When blood gases are available, they are most useful in evaluating the prog-

TABLE V

	Age at Onset	*X-rays*	*Clinical Findings*
HMD	Less than 8 hours	Diffuse granular appearance Air bronchograms	Premi plus conditions in Table I
Aspiration syndrome	Less than 8 hours	Sunburst appearance	Fetal hypoxia with or without meconium stained fluid
Intrauterine pneumonia	Less than 3 days	Generalized or localized infiltrates Air bronchograms	Conditions in Table III
Acquired pneumonia	Usually after 3 days	Localized infiltrates	Usually premature
CHD	Usually late 1st week or afterwards	May have cardiomegaly May have increased pulmonary vascular markings	May have congestive heart failure Usually will have a murmur
Pneumothorax	Any age		
Pneumomediastinum	Less than 24 hours	Air in mediastinum and sometimes around pericardium	Tachypnea with minimal or no dyspnea
Diaphragmatic hernia	Usually less than 8 hours	Stomach and intestine in pleural cavity	Scaphoid abdomen Shift of heart tones to left

ress of the disease and, to a lesser extent, the diagnosis. An elevated PCO_2 indicates that an infant is hyperventilating in response to a stimulus other than CO_2. A low pH indicates the presence of acidosis which may be respiratory or metabolic. From nomagrams or a blood gas slide rule, we can calculate a base excess. The larger the negative base excess (base deficit) the greater the metabolic acidosis. The metabolic acidosis is the result of anaerobic metabolism and can result from systemic hypoxia (a low arterial PO_2 usually when it is less than 35 mm Hg) or peripheral hypoxia from poor profusing of tissues as is seen in shock or sepsis. Following the PCO_2 and PO_2 is the best way of monitoring the progress of the disease.

Many aspects of treating respiratory distress are the same regardless of its etiology. Therapeutic procedures unique to some of the clinical situations have been discussed with the entity. This outline will offer information on how to correct some of the abnormalities present when infants have respiratory distress. As x-ray is the most important diagnostic study; maintaining a warm infant is the most therapeutic item.

(1) **Warmth.** Maintaining a normothermic infant is the most important factor in preventing respiratory problems or amelioriating those that exist. Radiant heaters in the delivery room and adequate incubators or radiant heat in the nursery are effective in preventing hypothermia. If radiant heat is not available in the delivery room, the infant should be dried off and placed in a prewarmed incubator or prewarmed blanket. Babies often become chilled during their initial washing which significantly increases their risk for developing respiratory distress. Care must be taken to avoid this in any infant at risk for respiratory distress.

(2) **Fluid and Calories.** Infants with dyspnea may increase the energy expended for respiratory work manifold. Calories must be supplied to meet these demands. This can be done with 10 per cent glucose solution given at the rate of 65 ml/kg on the first day and increasing to 80 ml/kg on the second or third day and up to 100 ml/kg by the end of the first week. Sodium needs to be added on the second day in a concentration of 15 to 20 mEq/L and increasing to 25 to 30 mEq/L by the end of the first week. $K+$ in a concentration of 20 mEq/L should be added on the second day if hyperkalemia is not present, and the infant is voiding. The concentration is 20 mEq/L. Electrolytes should be done daily while on IV fluids.

(3) **Buffers.** Infants with metabolic acidosis (i.e. base excess of -4 mEq or greater), need buffering. Sodium bicarbonate is the most commonly used buffer. It is usually given in a dilute solution (10 ml 7.5 per cent Na bicarbonate with 90 ml D10W). This can be safely used in infants with mild to moderate HMD or pneumonia. If blood gases are available, the degree of negative base excess determines the amount of bicarbonate needed and can be determined from the following formula: ml of bicarbonate = (base deficit) $\times$ (wt. in Kg) $\times$ 0.22. The above described solution given at 65 to 100 ml/kg will usually correct the base deficit except in the most severely ill infant or in the infant following a cardiorespiratory arrest. Following base deficit will indicate when bicarbonate is no longer needed (and the IV fluid will have NaCl added to meet the sodium requirement). Bicarbonate is of no value when PCO_2 of 70 or above is present because it cannot buffer if CO_2 is not eliminated by the lungs. At PCO_2 of 60 or higher, the reported base deficit may be much higher than really exist.

(4) **Oxygen**. The hypoxia associated with many kinds of respiratory distress requires treatment with supplemental oxygen. The goal is to maintain sufficient systemic oxygenation to prevent progression of metabolic acidosis from hypoxia. If blood gases are not available, then sufficient oxygen is given to prevent cyanosis, but the infant should be carefully watched so that the concentration can be reduced as rapidly as possible. Oxygen should be withdrawn gradually and never suddenly stopped. If blood gases are available, 100 per cent oxygen is given by face mask at 10 L. per minute and after allowing 15 minutes for equilibration, arterial samples are taken. If the PO_2 is greater than 160, the oxygen concentration is reduced by pulling the face mask back (never by decreasing the flow since this might lead to CO_2 retention by rebreathing). When the mask is three inches from the face, the concentration is about 70 per cent and may be switched to isolette oxygen. The oxygen concentration is reduced over a four to six hour period until a PO_2 of 45 to 50 mm Hg is reached and the concentration is further reduced as the PO_2 rises. If the PO_2 is between 100 and 160 mm Hg, the reduction in concentration is carried out over an eight to 12 hour period. If the PO_2 is less than 100 mm, the reduction in oxygen concentration is done very cautiously. When oxygen is used, it must be humidified. This is best done with a heated nebulizer or a jet nebulizer for both mask and isolette oxygen. When oxygen is given by mask, the eyes must be protected from drying by placing two drops of methylcellulose in the eyes every two hours.

(5) **Antibiotic therapy.** Anytime an infectious process is suspected, antibiotic therapy should be initiated. The previous paper, "Acute Bacterial Infections in the Newborn" (J.M.S.M.A. XI: 493-500 (Sept.) 1970), outlines the indications for and choice of antibiotics in certain critical situations that recur in the nursery. In Table III, a list of situations is given in which the authors feel the infant should be given antibiotics.

(6) **Shock.** Hypotension is frequently seen in infants with respiratory distress. The administration of blood has been demonstrated to restore the blood pressure and diminish the severity of respiratory distress present. Shock can exist in infants without clinical manifestations. When decompensation occurs, one sees bradycardia (rapid thready pulse is almost never seen in infants), peripheral vasoconstriction often manifested as an ashen grey appearance with cold extremities (this may not occur until shock is profound) and, decreased renal output, usually a very late manifestation of shock in infants. Blood pressures can easily be followed in these children using a Doppler ultrasonic apparatus.* Shock in infants is treated with whole blood using 10 ml/kg and repeating, if necessary, until the blood pressure is normal. Salt poor albumin or plasmanate can be used while the blood is being cross matched. Normal systolic BP's vary by weights, 1500 grams 45-50 mm Hg; 2000 grams 50-55 mm Hg; 2500 grams 55-65 mm Hg. Values more than 10 mm Hg below these represent shock. Correction of shock usually significantly decreases the degree of respiratory distress.

The use of ventilation in the nursery can save some infants who would otherwise die. The criteria for ventilating are an infant weighing greater than 1500 gms who has no evidence of CNS damage with PCO_2 of 70 mm and rising, a PO_2 less than 40 cm on 100 per cent O_2 or apnea. The survival rates vary by series but are usually 50 per cent or better. The long term follow-up studies from Vanderbilt show these children to be similar in intellect and neurological development as compared to their siblings. ★★★

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* This apparatus is available from Parks Electronic Labs, 12770 SW 1st, Beaverton, Oregon 97005.

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WIN, PLACE, AND SOME SHOW

The anxious wife confided in the psychiatrist: "Oh, doctor, I am so worried about my husband. He thinks that he is a race horse. Can you help him?"

"Yes, Mrs. Jones, I think I can," the physician replied, "but these cases sometimes require long therapy and are consequently costly."

"Money is no object, doctor," she said. "My husband got $100,000 when he won the Belmont last week."

Specificity of EKG Changes in Strokes

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Two hundred and eighty-five electrocardiograms including 110 acute stroke electrocardiograms were reviewed in 116 young stroke victims in an attempt to determine the specificity of EKG changes in strokes. From this review, the authors concluded that while definite EKG changes do occur in stroke patients, these are non-specific and hypokalemia may play an etiologic role in the genesis of at least some of these. In view of this correlation, they feel that stroke patients should be monitored for changes in serum electrolytes in order to prevent the occurrence of serious disturbances in the latter.

VARIOUS ELECTROCARDIOGRAPHIC changes in patients with strokes have been described in the literature.[1–6] These have included T-wave changes, ST segment deviations, prominent U-waves and prolongation of the Q-T (or Q-U) intervals. As will be noted, some of these changes are quite similar to those which have been described for hypokalemia.[7–9] In patients with subarachnoid hemorrhage, several authors[1, 2] have also been impressed by the ischemic appearance of the electrocardiogram. In their opinion, the electrocardiographic changes have at times been sufficiently prominent to suggest myocardial injury or even infarction. Therefore, it appears to us that at least two major electrocardiographic patterns have been observed in connection with strokes, one impressively resembling hypokalemia and the other being suggestive of myocardial ischemia.

Because of the various electrocardiographic changes described in these patients, we attempted to determine the specificity of these changes and to seek explanations for their etiology. Accordingly, the following study was undertaken.

In an attempt to determine electrocardiographic specificity in strokes, the EKG criteria listed in Table 1 were applied to the interpretation of 285 unknown electrocardiograms obtained from 116 young stroke victims (Table 2). From this group of tracings, only those meeting impressively several of the listed electrocardiographic criteria were selected as acute stroke tracings. The latter were defined as electrocardiograms obtained within two weeks of the actual intracranial event. Of the electrocardiograms read as acute stroke records, only those which were found to have been obtained within this two week time period were considered as correctly diagnosed.

The criteria applied in our electrocardiographic interpretations included, among others, elevated or depressed ST segments, prominent U-waves, prolongation of the Q-T (Q-U) intervals and T-wave inversions. All of the patients involved had suffered some type of cerebrovascular episode at some time but of the 285 electrocardiograms reviewed, there were only 110 which had been obtained within two weeks following a stroke. Furthermore, at the time of review, the electrocardiographer had no information regard-

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ing the exact number of acute stroke EKG's included among the cardiograms to be interpreted.

Ten electrocardiograms were selected as "acute stroke records." This diagnosis was correct in seven (70 per cent) and therefore suggested a moderate degree of specificity of the EKG changes occurring in strokes. However, we found this specificity to be more apparent than real. In four patients in whom the electrocardiogram was correctly interpreted, potassium values done within 24 hours of the electrocardiogram were available. In two of these patients, the potassium values were clearly below normal (3.0 and 2.9 mEq/l) and suggestively low (3.6 mEq/l) for our laboratory in a third patient. Additionally, in two of the three electrocardiograms incorrectly read as acute tracings, potassium values were available and were found to be subnormal in both (2.7 and 3.3 mEq/l). These findings suggested that low potassium might explain some of the changes seen in acute stroke EKG's (Figure 1). It is interesting to note, that of the seven correctly diagnosed electrocardiograms, all seven patients had experienced intracranial bleeding (either ruptured aneurysm or intracerebral hemorrhage).

ISCHEMIC CHANGES

Since we applied the criteria listed in Table 1 in our EKG interpretations, it is not surprising that several of our correctly diagnosed acute stroke tracings exhibited changes consistent with ischemia. One of these exhibited changes which were highly suggestive (Figure 2), including horizontal elevations of the ST segment in leads $V_{2\text{-}3}$ with negative T-wave spikes in $V_{4\text{-}5}$. In a second tracing impressive horizontal ST segment depressions were noted in leads $V_{5\text{-}6}$ (however, voltage criteria for left ventricular hypertrophy were met in this EKG). In two other correctly diagnosed tracings, minor T-wave changes were noted and isolated ST segment depressions were noted in still another.

TABLE 1

EKG CRITERIA APPLIED IN DIAGNOSIS OF ACUTE STROKE ELECTROCARDIOGRAMS

Prolonged Q-T (or Q-U) interval	Negative T-waves
Depressed or elevated ST segment	Wandering pacemaker
Tall U-waves	Bradycardia (or tachycardia)
Tall P-waves	
Large T-waves	

As pointed out by Lavy et al,[10] the genesis of the electrocardiographic changes in hemorrhagic and ischemic strokes may be quite different. It was the opinion of this group that the EKG changes in ischemic stroke probably preceded the cerebral event. They concurred with the concept that EKG changes in hemorrhagic stroke are probably caused by severe brain damage resulting from an acute rise in intracranial pressure.[11] Burch et al[3] reported EKG changes in 17 patients with strokes. The most pronounced changes in their series occurred in those patients with intracranial hemorrhage. It was their feeling that changes in the autonomic nervous system associated with strokes were possible contributors to the electrocardiographic patterns observed. They also felt that electrolyte disturbances may have been at least partially responsible for some of the EKG changes which they noted.

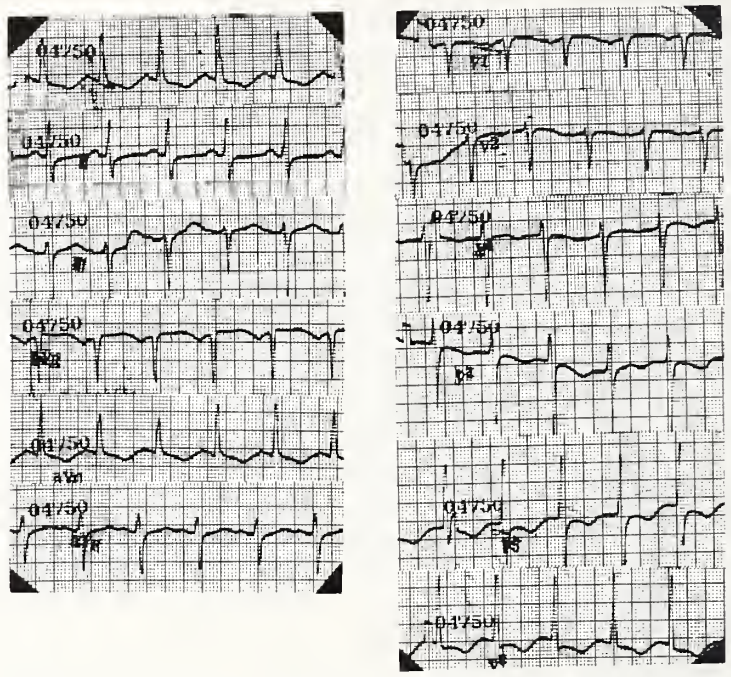


Figure 1. Acute stroke EKG with hypokalemic features. Note the prolonged Q-T (or Q-U) intervals especially in leads I and III and T-wave changes throughout.

Others,[4] however, have found no definite correlation between the serum electrolytes and the EKG changes found in strokes. Wasserman et al in a study of 12 stroke victims (principally subarachnoid hemorrhage) found no correlation between serum electrolytes and the electrocardiographic findings in 10 of their 12 patients. They felt, however, that the possibility of electrolyte disturbances within the heart itself could not be entirely excluded.

Cropp and Manning[2] studied EKG findings in 29 patients with subarachnoid hemorrhage. These authors were particularly impressed by the ST segment elevations or depressions which they

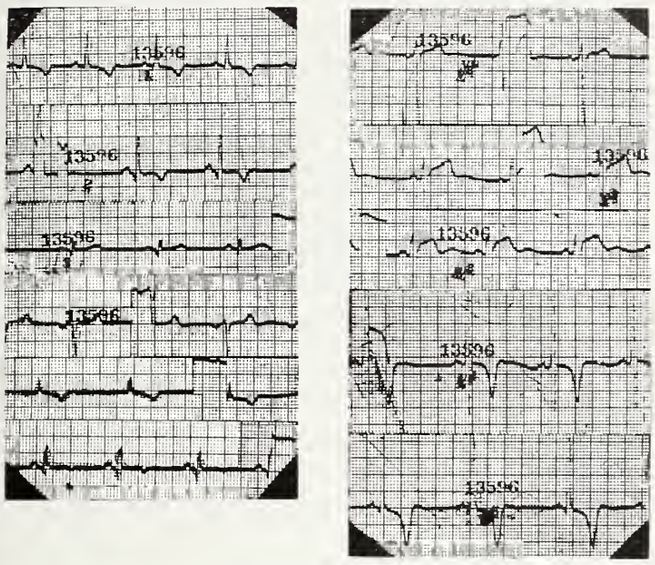


Figure 2. Acute stroke EKG with ischemic characteristics. Note the ischemic appearing T-waves in leads II, AVL, $V_{5\text{-}6}$.

observed and also by the prolonged Q-T intervals noted in some of their patients. In four patients, from a group of 15 with electrocardiograms suggesting myocardial infarctions or ischemia, postmortem examinations revealed a normal heart. These authors hypothesized that the etiology of the EKG abnormalities in the presence of a normal heart were lesions in the region of area 13 on the orbital surface of the frontal lobe. Ananthachari and Anto,[1] in a study of 20 patients with subarachnoid hemorrhage, concluded that the EKG findings were a result of the intracranial lesion rather than electrolyte disturbances or primary cardiac damage. They felt that the electrocardiographic changes observed reflected abnormalities in cardiac function although the latter did not seem to have an adverse effect on the patients' clinical progress.

POSSIBLE EXPLANATIONS

From the above discussion, it is obvious that the exact etiology of the EKG findings in hemorrhagic stroke has not been clarified though several possible explanations have been advocated based on the findings of different observers.

We concur with others[1–6, 10] that definite EKG abnormalities may be seen in the cardiograms of stroke patients. However, these do not seem to be highly specific when the criteria suggested in the literature are applied to "unknown" electrocardiograms. Furthermore, some of these changes may be due to hypokalemia. This appears to be particularly likely in the case of intracranial hemorrhage. Since there seems to be a correlation between the electrocardiographic changes and low serum potassium in some stroke victims, we feel that stroke patients should be monitored for changes in serum electrolytes in order to prevent the occurrence of serious disturbances in the latter.

The genesis of the ischemic appearing changes described in the electrocardiograms of some patients with subarachnoid hemorrhage remains unclear with several authors[1, 2] postulating that these arise in some manner from the intracranial lesion itself.

TABLE 2

STROKE DIAGNOSIS IN 116 PATIENTS AGED 15 TO 50

Diagnosis	*Number of Patients*
Cerebral thrombosis	48
Cerebral embolus	9
Cerebral aneurysms	19
Subarachnoid hemorrhage (of unknown etiology)	5
AV malformations	3
Intracerebral hemorrhage	21
Transient ischemic attack	11

SUMMARY

Two hundred and eighty-five electrocardiograms including 110 acute stroke electrocardiograms were reviewed in 116 young stroke victims in an attempt to determine the specificity of EKG changes in strokes. From this review we concluded that, while definite EKG changes do occur in stroke patients, these are non-specific and hypokalemia may play an etiologic role in the genesis of some of these. ☆☆☆

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Aided by NHI Research Grant 61953, HEW Grant 3G02RM000570151 and USPHS Grant 5G03RM00057-02.

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HORROR-SCOPES

Astrology has become a popular subject with daily horoscope columns in the newspapers. Here are a few horoscopes as they might have been:

Paul Revere (Capricorn, Dec. 22-Jan. 19): Relax today and enjoy unexpected company. Don't spread idle gossip. Red is today's lucky color.

Neil Armstrong (Leo, July 23-Aug. 22): Advisable not to take trips right now. Other than that, the sky is the limit.

Noah (Aquarius, Jan. 20-Feb. 18): Difficulties will double today. Family pets play havoc with nerves. Save something for a rainy day.

Alexander Graham Bell (Pisces, Feb. 19-Mar. 20): Call upon a friend today. Tell of accomplishments. This day could be a real bell-ringer.

Julius Caesar (Aries, Mar. 21-Apr. 19): Close friends will contact you today with piercing issue in the Senate.

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Radiologic Seminar CIV
Gastric Obstruction Due to Impaction of a Gallstone in the Duodenum

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Jackson, Mississippi

OBTURATION OBSTRUCTION has been defined as the plugging of some portion of the intestinal tract by a foreign body which ranges from gallstones, enteroliths to masses of worms to such rarities as dental plates. This case represents one due to impaction of a gallstone in the duodenum producing obstruction to the gastric outlet.

Gallstones are the most common form of such obturation obstruction and find their way into the intestinal tract by erosion through a diseased gallbladder into some part of the intestinal tract, usually the duodenum. Stones small enough to pass through the biliary tract into the intestine usually do not produce obstruction. The most common site of impaction is the terminal ileum but in one reported series, 17 out of 239 cases were found in the duodenum.

The possibility should be thought of in any elderly person who presents himself with symptoms and signs of intestinal obstruction and having a history of gallbladder disease, particularly following a recent episode of severe gallbladder colic.

Gallstone ileus is uncommon because of early recognition of gallbladder disease and surgical removal. It is a serious disease however, because of its age incidence associated with intestinal obstruction.

Early diagnosis has been improved by radiographic recognition of which the most significant findings are: (1) Direct visualization of the stone in the intestinal tract or its demonstration by contrast media; (2) Signs of intestinal obstruction; and (3) Demonstration of air in the biliary radicles.

This case is that of a 53-year-old white female

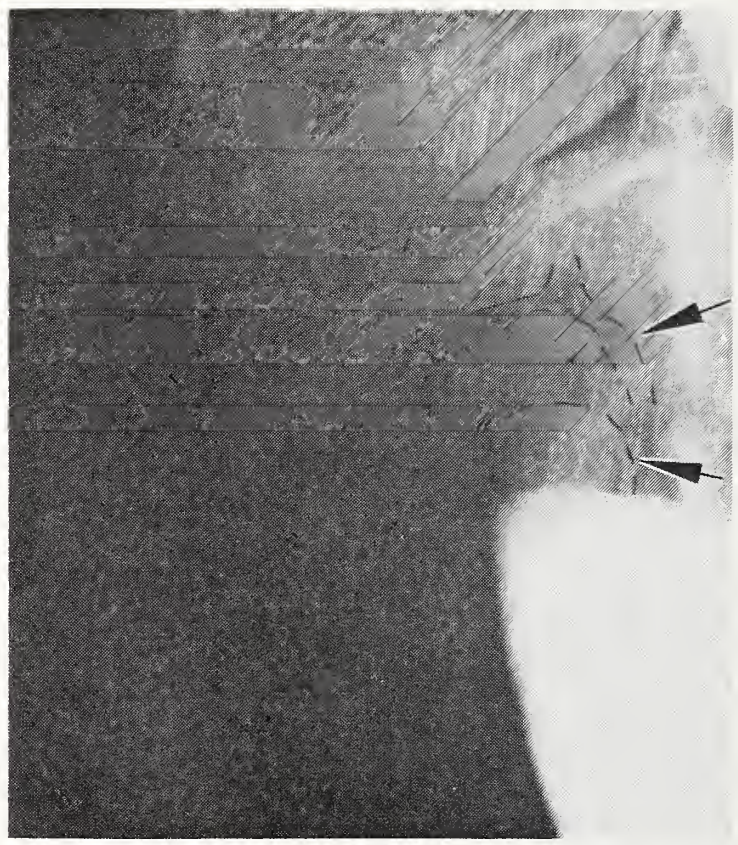


Figure 1. (a) Upper arrow demonstrates air in the upper biliary radicles (retouched). (b) Lower arrow demonstrates radiolucent filling defect in the duodenal bulb.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, St. Dominic-Jackson Memorial Hospital.

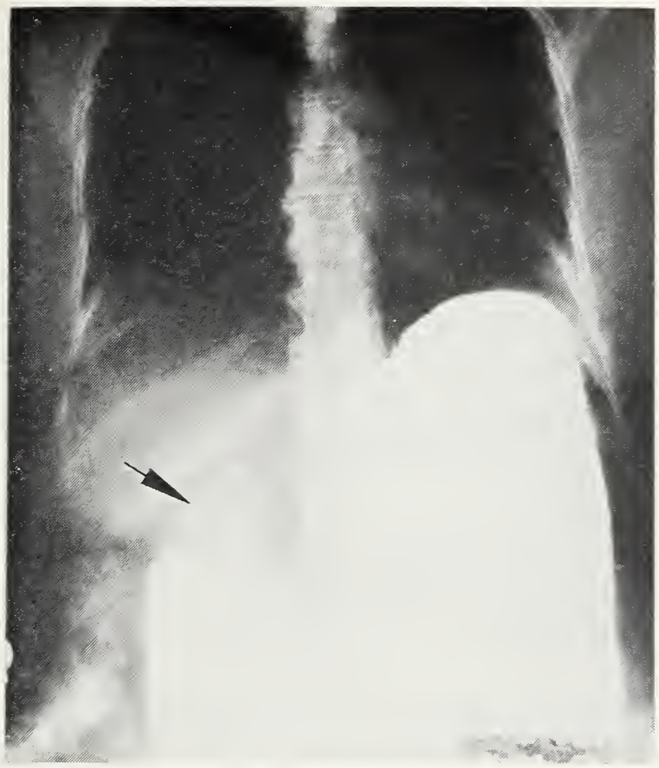


Figure 2. Arrow demonstrates radiolucent filling defect in the duodenal bulb with thin rim of barium surrounding the gallstone. The stomach is dilated and filled with barium and fluid.



Figure 3. Intravenous cholangiogram showing slight dilatation of the common duct with partially opacified gallblader (arrows).

who was admitted with epigastric pain, nausea and vomiting of three to four weeks' duration, with a previous history of what in all probability represented previous episodes of gallbladder colic.

Radiographic studies of the upper G.I. tract revealed marked dilatation of the stomach due to obstruction of the gastric outlet by what appeared to be a large radiolucent gallstone impacted in the duodenum. Air was also identified in some of the upper biliary radicles. An intravenous cholangiogram revealed that moderate dilatation of the common bile duct with what probably represented a fistulous communication with the duodenal bulb.

At surgery the presence of fistulous tract was found extending from the gallbladder to the duodenum. A large gallstone was present impacted in the duodenum causing obstruction to the gastric outflow tract. A gastrotomy was done and the gallstone extracted from the duodenum.

She was discharged on the tenth postoperative day after an unremarkable postoperative course. A cholecystectomy was planned at a later date.

★★★

969 Lakeland Drive (39216)

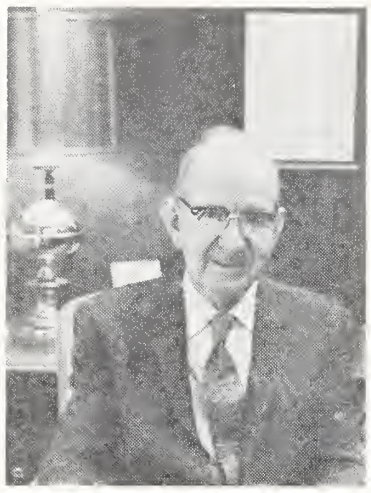
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EFFECTIVE ARGUMENT

Making a plea for a furlough because his wife needed him at home, the private's commanding officer asked him, "Do you place your wife before your duty to your country?"

"Sir," answered the private, "There are 11 million men taking care of the country, but as far as I know—I'm the only one taking care of my wife." He got the furlough.



The President Speaking

'Answering the Attack'

PAUL B. BRUMBY, M.D.
Lexington, Mississippi

Your delegation to the recent AMA clinical convention at Boston became very involved protesting the slanderous and untrue remarks made by two panelists at the Medical Service Conference. One was a student at Howard University and the other an intern at Freedman's Hospital. This platform forum by AMA was used to abuse Quitman County, its physicians and officials, the hospital at Clarksdale, the state medical association, and the panelists threatened to take legal action against the State Board of Health because of the harassment it had caused their professor of medicine who was applying for a license by reciprocity. They made the statement that people would go to jail to protest a failure to license a medical graduate simply because he was disadvantaged or black.

Our Dr. Hicks rose on the floor of the House of Delegates and in a statement of truth and conscience, denied this out of hand. He stated that these remarks were both untrue and inflammatory. This was ably seconded on a point of personal privilege by Dr. Sweeney of Michigan. The House of Delegates condemned this intern and appended this condemnation to a speech but this did not undo the injury done to us.

When we returned home, we had received a program and invitation to meetings on rural health to be held in Atlanta, and this intern, George Tolbert, was on the program panel. The chairman of the Rural Health Council had promised that if we could prove these men untrue, they would never again be afforded a platform to defame Mississippi.

The chairman was immediately contacted by the Mississippi delegation as was the moderator of the panel on which the man spoke. After we confronted each and every person who might help us right this wrong, this rural health conference has been restructured.

We from Mississippi were heard at this meeting although we might not have had listeners. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 2
FEBRUARY 1971

EDITORIALS

Licensure and Manpower: Crisis, Problem, or Dilemma?

I

Does a crisis exist in licensure of health occupations? Are the several states inadvertently creating a system of craft guilds or unions among allied health professions through licensure laws? Are we, in an otherwise sincere effort to meet the challenge of health manpower shortages, actually diminishing the supply? Are health occupation licensure laws really tailored to accommodate the least qualified in the name of inclusiveness?

These and a host of other questions on licensure are being raised locally and nationally in medical circles. While none of the crucial questions propounded may be answered only in the affirmative, it is apparent that there are problems and, to say the least, multiple issues involved in health occupation licensure. So say the American Medical and American Hospital associations who now agree that there should be a nationwide moratorium on creation of new and additional health occupation licensure laws pending further study and assessment of issues involved.

The seriousness of the situation is underscored in many ways. A growing body of opinion seeks uniform, national licensure laws at the federal level. This is not only highly undesirable but dangerous as well, because with these uniform national standards must also come national norms for care minimums and individual performance.

Within the licensure dilemma, there is a good bit more than the surface issue of separating the qualified from the unqualified. There are questions of sufficient supply, levels of professional responsibility, and the quality of care which can and will be delivered. What hangs on the wall affects us all.

II

With only rare exceptions, licensure of occupations and professions is a function of the states. Generally, licensure meets these criteria:

—The license, certificate, or registration is issued to an individual rather than to a company, partnership, or corporation.

—The license authorizes the individual to practice or engage in an occupation or profession, usually employing a particular identifying title.

—The license is granted on one or more of the following conditions: Having satisfied minimum educational or training prerequisites; having served an apprenticeship, postgraduate, or practice period; having demonstrated proficiency and knowledge through examination; giving evidence of good character and honorable intent; and having attained a given age.

During the first half century of our nation's history, only two professions were licensed by the states—medicine and law. Mississippi was

the second state of the union to enact medical licensure, passing the law in 1819, preceded only by South Carolina in 1817. Forty-two of the states and territories enacted medical licensure in the 1800's.

Almost without exception, medical licensure enactments in state legislatures were originated and supported by professional societies deeply concerned with education and qualification. Strong national professional organizations began to appear just before and immediately after the War Between the States:

—American Medical Association, 1847.

—American Pharmaceutical Association, 1852.

—American Dental Association, 1859.

—American Veterinary Medical Association, 1863.

—American Nurses Association, 1896.

The Mississippi State Medical Association was founded at Jackson on Dec. 15, 1856.

From a legal viewpoint, there are two types of occupational and professional licensure, mandatory and permissive.

Mandatory or compulsory licensure requires any individual practicing the occupation or profession to be licensed and prohibits all others from doing so.

Permissive licensure means that only persons holding a license are authorized to use a particular title designating the occupation or profession, but others are not prohibited from working in the field as long as they do not use the protected title or designation.

The trend is clearly toward mandatory licensure in the health professions. Medicine, dentistry, veterinary medicine, and most independent practitioner professions have long been under mandatory licensure laws. In Mississippi, 13 categories of health professions are licensed. Eleven are mandatory, the most recent addition being nurses in 1970, and only two, physical therapy and clinical psychology, are permissive.

III

Our efforts to increase the supply of health services through use of allied health professionals in the present licensure climate give rise to a curious paradox. On the one hand, we need more and better members of the allied health professions, even new workers in new fields. Yet we shudder at the thought of more fractionalization and fragmentation, resulting inevitably in overspecialization.

To assure the quality of services and patient safety, we must impose limitations through licensure mechanisms upon those permitted to practice, yet we have an urgent need to extend flexibility in profitable employment of available manpower. More frequently than not, limitations implicit in licensure inhibit development of this flexibility. And we are logically and understandably reluctant to let the bars down and thereby frustrate and defeat our goals and purposes.

Some of the existing potential and proposed alternatives to conventional licensure hold promise, especially those which provide for state and local determination, as opposed to national compulsory regimentation. Others would merely intensify or exacerbate problems. Five such alternatives are:

Peer Certification of Registration. This professional warranty is generally more exacting than licensure, being dependent upon completion of accredited training and maintenance of competency. Peer certification responds more quickly to advances in the art and science than licensure, but its limitations include bars to certification without accredited training, restriction on upward and lateral mobility in careers, and domination of the profession by educators.

Uniform Licensure Codes. Proposed by the National Advisory Commission on Health Manpower, uniform licensure codes would impose single national standards on all licensure. This would cut the states—and hence, the local professional communities—out of the qualification picture and if anything, restrict entry into the field. The problem of inapplicability of national standards to regional resources and needs would be magnified.



"It would be a lot easier for us, General, if you would consent to removing your medals."

Institutional and Independent Practitioner Licensure. This concept holds out interesting potential. Independent practitioners, i.e., physicians, dentists, etc., to whom the public has direct access for individually rendered professional services, would be licensed by the states as is now done. But dependent practitioners, i.e., nurses, physical therapists, and laboratory technologists, would be unlicensed *per se* but would be accountable to the institution or licensed independent practitioner who is, in turn, accountable to the state licensure authority. Problems are seen, however, in applying this concept to the large numbers of allied professional personnel who work neither for an institution nor independent practitioner.

State Medical Board Registration. A much simplified alternative is to place all allied health profession licensure under the state medical licensure board. This would assure that there would be no proliferation of licensed health occupations which become frozen into rigid classifications, only to create new shortages. The chief problem in bringing this concept into fruition would be the certain unanimous objection of existing allied professional licensure bodies.

Increased Public Representation. This is the idea of adding consumers to all health licensure bodies "just to keep them honest." It is argued that medical boards would be more reluctant to go easy on an addicted physician if public representatives were in the group. On the other hand, there is a dilution of professional authority and administration of a field by those having no competence in it.

IV

Some will conclude that allied health professions licensure is in a crisis state, while others will insist that we do not have nearly enough of it. Both the American Medical and American Hospital associations have said stop now, declare a moratorium, and take stock.

AMA urges that state medical practice acts be amended, where necessary, to remove barriers to increased delegation of tasks to allied health professionals by physicians. AMA also argues that educational equivalency measures and job performance tests should be acceptable alternatives to training minimums in accredited institutions.

At the root of it all, however, is the crying need for continuing education in organized, accredited postgraduate programs. Medicine is leading the way, and the allied professions will do well to follow. Our Mississippi Postgraduate Institute in the Medical Sciences, a joint project of the state medical association and University Medical Center, is years ahead of national thinking in offering postgraduate training to the allied fields.

The problem is difficult, with or without a crisis, real or fancied. It demands study by physicians and medical leadership in seeking solutions, because in the final analysis, only the physician can deliver the care with full professional responsibility.—R.B.K.

The AP Owes M.D.'s an Apology

The Associated Press is a reliable, objective wire service, reporting the news fairly and promptly. But a recent breakdown in reliability and objectivity was not only a beaut of misinformation but also an unfortunate and near-libelous charge against the medical profession.

Said the AP: "The aged must pay 6 per cent more for supplemental Medicare benefits next July 1 largely because of rising doctors' charges. . . ." This had reference to the HEW announcement that Part 1-B premiums will go to $5.60 per month for both recipient and government from the present $5.30 for fiscal 1972.

"Most of the latest increase was attributed to the expected 6.7 per cent jump in the amount of doctors' fees covered by Medicare," the AP story said in part. This is unadulterated hogwash, because physicians' fees under Medicare have been frozen since Dec. 31, 1968. The wire service story amounts to nothing less than a dissimulation, even if careless and inadvertent.

The secretary of HEW, Elliot L. Richardson, issued a detailed statement on the premium increase, and AP ought to have published it or the substance of it in clear context. The secretary said that the "items which make up the increase are as follows: 31 cents to cover an estimated increase of 6.7 per cent in the level of physicians' fees recognized by the program in physicians' services. . . ." All of which is to say that Medicare, as has been outlined in pending legislation and announced policy of HEW, plans to be a little more realistic in compensation for professional services.

The secretary candidly admitted that 20 cents from the last Part 1-B premium increase of $1.30 has not been used, so combined with the coming 30 cents increase, Medicare will have another 50 cents to put into the program. This includes growing numbers of recipients and mounting institutional costs for services covered under Part 1-B.

It is distressing to reflect upon the frantic screams and cries raised by journalists in the name



of the First Amendment only to see such a failure of journalistic integrity. We remind the AP of Chief Justice Marshall's words that "freedom of speech does not include the right to yell 'fire' in a crowded theater" nor does it confer a license to misreport the news to the detriment of others. —R.B.K.

Politically, It PAC's a Wallop!

Just how much good for medicine is purchased with voluntarily given MPAC (Mississippi Medical Political Action Committee) and AMPAC (American Medical Political Action Committee) dollars? The answer is plenty!

AMPAC, in concert with state PAC's, participated in Congressional elections in 1970 in almost every state. It posted a 75 per cent record, meaning that three out of every four candidates it backed were elected. And there can be no argument about PAC dollar effectiveness, especially in view of the scoreboard for the 92nd Congress.

The incumbent President's party historically loses 40 seats in the House of Representatives in an off-year election or the election between Presidential voting years. The final vote in the House went to 255 Democrats and 180 Republicans against 243 Democrats, 187 Republicans, and five vacancies in the 91st Congress. Historically since the Roosevelt years, Republicans have been more conservative than Democrats in voting records. Of course, Southern Democrats vote as conservatives in a class by themselves.

The Senate scoreboard recorded points for the conservatives. Ultra-liberal Sens. Charles E. Goodell (R.,N.Y.), Joseph D. Tydings (D.,Md.), and Albert Gore (D.,Tenn.) were defeated by avowed conservatives. Sen. Ralph W. Yarborough (D.,Tex.), another liberal who has consistently voted against medicine, was purged by his own party in the primaries at home. But there were liberal victories, too, with the defeat of Sen. George Murphy (R.,Calif.) and Sen. Ralph T. Smith (R.,Ill.).

The complexion of the Senate goes to 54 Democrats, 44 Republicans, one Independent, and one Conservative in the 92nd Congress. In the 91st, there were 57 Democrats and 43 Republicans. This year, the party swing vote is, at worst, only six votes. This does not take into account the 10 to 14 conservative votes of Southern Democrats or the six to 10 liberal Republicans. Purely liberally-conservative battle lines will be closely drawn.

When the forces and resources of AMPAC, state PAC's, and local physician support committees are combined, there is political clout available for the candidate. No medical political action committee is organized along partisan lines. The whole idea in PAC activity in the candidate and his voting record, not the party. More than that, PAC support is positive, being for the man who has the record.

A medical political action committee is a voluntary, nonprofit, unincorporated organization which is totally apart from a state medical association. Dues for PAC membership are not deductible for income tax purposes, and of course, there is no compulsion to join. Typically, across the nation, about half of the private practitioners belong. The record is a little better than that in Mississippi.

While the Mississippi Congressional delegation can usually be counted on to take a conservative position, it goes without saying that the majority of the Congress does not. AMPAC dollars from Mississippi physicians do not materially alter the political inclinations of our own Senators and Representatives, but they do help in electing conservatives in other states. It is just as important to elect a conservative from Minnesota and Missouri as from Mississippi.

The political climate for American medicine and its private care delivery system has not been good in the decade of the 1960's. It will take hard work to swing the pendulum back, but the trend has appeared. PAC dollars help. And memberships are accepted every day in the year.—R.B.K.

We Live in Incredible Times

Nobody need be reminded that we live in unbelievable and incredible times. Our nation wages a war without a name which our military is forbidden to win. In the name of poverty eradication, we subsidize the slothful and line the pockets of those who would destroy the government which supports them. We penalize the provident and tax the productive.

But almost nobody, even those aware of the incredible times in which we live, is quite ready for a New York Family Court decision which was handed down late last year. It was an intra-family squabble with strong medical overtones, but it is one of the best examples yet of runaway liberalism which undermines the most basic and fundamental institutions of society.

A 20-year-old daughter of a New Yorker has

been enrolled at the University of Louisville in Kentucky. Last year, she was placed on academic probation because of low grades, and she was experiencing emotional difficulty. In defiance of her father's specific instructions, she moved off-campus and even sold her automobile. Her father described her life style as that of a hippie. He withdrew support funds for attending the university.

In November of 1970, the daughter sued her father for support and college tuition, and the Family Court awarded her $5,750. It further decreed that unless the father deposited the money by December 28, he was to be jailed for 30 days. He has appealed the decision.

The daughter moved back on campus under advice by the university psychiatrist. She was said to have improved her academic work. The matter is still in litigation.

A prominent New York attorney was quoted as saying that "any minor would be able to set up housekeeping away from home and scornfully badger the father by court proceedings to underwrite any manner of living approved by the mindless courts."

The trial judge, Millard L. Midonick, said in his decree that "I have been sworn to uphold legal rights of daughters as well as fathers." The meat of his decision, however, was wrapped up in this conclusion: "At some point, minors must have some legal right of their own views and need for their independent and painful transition from minority to adulthood, short of matching every fancy of their parents." He said that the plaintiff daughter had shown herself to be mature and capable of continuing school while cooperating with a psychiatrist.

We live in incredible times.—R.B.K.

Auto Safety and the Right Figures

It is pretty easy to get the impression that the motoring public is merrily driving to the graveyard, what with traffic fatalities as commonplace as they are. Last year, nearly 58,000 Americans perished in automobile mishaps. Worldwide, over 200,000 died in auto accidents. Yet, the United States has the best motor vehicle safety record, as demonstrated by findings of the Metropolitan Life Insurance Co. in a recent study.

As with the prophets of doom, gloom, and assorted bleeding-heart anti-U.S. leanings, Americans are usually made to appear the crazed, drunken killers on the superhighways. In fact, the death rate per 100,000 population in the United States for auto accidents is the second highest in the world, deferring only to the mad West Germans. The figure is phony, because it does not take into account the extent of motor vehicle ownership or the degree to which automobiles are used.

The U.S. leads the world in automobile ownership and use. We have 508 cars for every 1,000 citizens. In contrast, most European nations have only one auto for every four or five citizens. We drive more than twice as much per auto as any other nation, too.

Still another way of computing the death toll —and a little better than the per 100,000 population method—is the rate per 100,000 registered motor vehicles. Under this method, the United States has the second lowest rate, 54.5 against ranges up to 125.2 in West Germany. Norway has the lowest, not a remarkable statistic, considering that half of that country is in the Arctic Circle.

But when related to mileage, ownership, and population, the auto death hazard is an altogether different picture and a much more accurate one, at that. Under these criteria, Japan takes the clear lead for the dubious honor of highway killer No. 1, whereas it is third lowest



"The others? . . . I don't know . . . They left for some reason."

in the fatality rate per 100,000 population. West Germany comes in sixth. But for two decades, the United States has the lowest fatality rate on deaths per 100 million miles. Interestingly enough, this is the method of computing air safety for scheduled air lines, the passenger fatalities per 100 million seat miles.

We can and must better the best safety record, because the vast majority of auto accidents claiming lives are preventable. We must do more about the drunk driver with chemical tests for intoxication, tougher penalties, and stiff insurance regulations. The speedster must slow down or go. The reckless should also not be long for neglect, either. It's a matter of your survival.—R.B.K.

POSTGRADUATE CALENDAR

UNIVERSITY MEDICAL CENTER POSTGRADUATE EDUCATION

February 18, 1971

NEUROLOGY SEMINAR: SEIZURES
University Medical Center, Jackson
February 18, 1971, beginning at 8:30 a.m.

Sponsored by The University of Mississippi School of Medicine postgraduate education committee

Participants:

Alfred Brann, M.D., assistant professor of pediatrics, assistant professor of medicine (neurology) and instructor in physiology and biophysics, The University of Mississippi School of Medicine

Robert Currier, M.D., professor of medicine (neurology), Chief, Division of Neurology and co-director, Mississippi Regional Medical Program stroke unit, The University of Mississippi School of Medicine

Nenad Grcevic, M.D., professor of neuropathology and chairman of the department, The University of Zagreb School of Medicine, Yugoslavia, and visiting professor of pathology, The University of Mississippi School of Medicine

Armin Haerer, M.D., associate professor of medicine (neurology), The University of Mississippi School of Medicine

Bernard Patrick, M.D., associate professor of neurosurgery, The University of Mississippi School of Medicine

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Ancel C. Tipton, M.D., instructor in medicine (neurology) and director of electroencephalography, The University of Mississippi School of Medicine

Thursday Morning

SEIZURE TYPES
Dr. Currier

EEG DIAGNOSIS OF EPILEPSY
Dr. Tipton

SEIZURES IN INFANTS AND CHILDREN
Dr. Brann

Thursday Afternoon

PATHOLOGY OF EPILEPSY
Dr. Grcevic

MEDICAL TREATMENT OF SEIZURES
Dr. Haerer

SURGICAL TREATMENT OF SEIZURES
Dr. Patrick

March 5, 1971

IMMUNE FACTORS IN KIDNEY DISEASE AND RENAL TRANSPLANTATION

Guest speakers for this one-day postgraduate course include Dr. Clark West, University of Cincinnati pediatric nephrologist, and Dr. William Klein, Duke University nephrologist. Presented by The University of Mississippi School of Medicine postgraduate education committee, the seminar is supported by the Kidney Foundation of Mississippi.

MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

March 1-5, 1971

GASTROENTEROLOGY INTENSIVE COURSE

University Medical Center, Jackson
March 1-5, 1971, beginning at 8 a.m.

Sponsored by The University of Mississippi School of Medicine postgraduate education committee, with the support of the Mississippi Regional Medical Program

Coordinator:
Lidio O. Mora, M.D., associate professor of medicine and chief of the division of gastroenterology, The University of Mississippi School of Medicine

The year's second session, this one-week intensive course will review registrants on management of common conditions. Curriculum, stressing endoscopy of all kinds, especially rectal sigmoidoscopy, will feature rounds, seminars and lectures. Participants will be five drawn from the 40 state family physicians currently enrolled in the Mississippi Postgraduate Institute in the Medical Sciences, which is supported by the Mississippi Regional Medical Program.

CIRCUIT COURSES

SOUTHWEST CIRCUIT

Natchez—February 16—Session 2; Jefferson Davis Memorial Hospital, 7:30 p.m.
Session 2—Carcinoma of the Thyroid, Dr. Coupery Shands
Presentation and Diagnosis of Hypothyroidism and Hypoparathyrodism, Dr. Herbert Langford

SOUTHERN CIRCUIT

Gulfport—February 3—Session 2; Gulfport Memorial Hospital, 6:30 p.m.
Bay St. Louis—March 3—Session 3; Bay-Waveland Yacht Club, 6:30 p.m.
Hattiesburg—February 4—Session 2; March 4—Session 3; Methodist Hospital, 6:30 p.m.

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Precautions: Should be used with caution in patients who have glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.
Adverse Reactions: Side effects reported to date have been predominantly related to rash (which requires discontinuation of medication) and headache and gastrointestinal distress, which are usually mild and transient with continuation of medication. In some cases severe persistent headaches may occur. In addition, the following adverse reactions to nitrates such as pentaerythritol tetranitrate have been reported in the literature: (a) Cutaneous vasodilatation with flushing. (b) Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. (c) An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur, even with the usual therapeutic doses. Alcohol may enhance this effect.
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PE-GP-11

Session 2—Clinical Management of Pneumonias, Dr. Joe R. Norman
Current Trends in Diagnosis and Management of Hepatitis, Dr. Lidio Mora
Session 3—Surgical Treatment of Coronary Artery Disease, Dr. Hilary Timmis
Current Practices in the Management of Chest Trauma, Dr. Richard Yelverton

EASTERN CIRCUIT

Columbus—February 23—Session 2; The Downtowner Motor Inn, 6:30 p.m.
Meridian—March 9—Session 1; East Mississippi State Hospital, 6:30 p.m.
Session 1—Management of Traumatic Renal Shutdown, Dr. Ben Johnson
Surgical Aspects of Urinary Tract Trauma, Dr. W. Lamar Weems
Session 2—Diagnosis and Management of Rheumatoid Arthritis, Dr. Thomas E. Wilson, III
Mechanisms of Anemia, Dr. Francis Morrison

FUTURE CALENDAR

February 3, 1971
CIRCUIT COURSE, GULFPORT

February 4
CIRCUIT COURSE, HATTIESBURG

February 16
CIRCUIT COURSE, NATCHEZ

February 18
NEUROLOGY SEMINAR: SEIZURES

February 23
CIRCUIT COURSE, COLUMBUS

March 1-5
GASTROENTEROLOGY INTENSIVE COURSE

March 3
CIRCUIT COURSE, BAY ST. LOUIS

March 4
CIRCUIT COURSE, HATTIESBURG

March 5
RENAL SEMINAR

March 8-12
NEPHROLOGY INTENSIVE COURSE
CARDIOLOGY INTENSIVE COURSE

March 9
CIRCUIT COURSE, MERIDIAN

POSTGRADUATE / Continued

March 24-26
CARDIOVASCULAR SEMINAR

April 5-9
PEDIATRICS INTENSIVE COURSE

April 6
CIRCUIT COURSE, MERIDIAN

April 13
CIRCUIT COURSE, MCCOMB

April 19-23
RADIOLOGY INTENSIVE COURSE

April 20
CIRCUIT COURSE, NATCHEZ

April 27
CIRCUIT COURSE, COLUMBUS

May 3-6
MISSISSIPPI STATE MEDICAL ASSOCIATION

May 11
CIRCUIT COURSE, MERIDIAN

Travelers Closes Tupelo Medicare Office

The Travelers Insurance Company, Part 1 B Carrier in Mississippi for Medicare, has announced the closing of the Tupelo Medicare office.

B. R. Gunter, administrator in Jackson, said that the Tupelo office's functions will be transferred to Jackson and claims will be processed there after Jan. 1, 1971.

The Medicare claims should be mailed to The Travelers, Medicare Office, P.O. Box 22545, Jackson, Mississippi 39205. The telephone number is 982-9411.

In early 1966 after Travelers was appointed Part 1 B Carrier for Mississippi, they opened four offices for regional services at Tupelo, Greenville, Hattiesburg and Jackson, with Jackson being the largest.

Gunter also said that the central office anticipates future closings of the Greenville and Hattiesburg offices.

Claims payments were made from these offices, but accounting and computer-based data processing have always been done in the home office in Hartford, Connecticut, according to Gunter.

Gunter succeeded Mr. Fouraker who opened the four offices in Mississippi initially and has since been transferred to Salt Lake City, Utah.

DEATHS

ARNOLD, HERBERT LEONARD, Tuscaloosa, Ala. M.D., Jefferson Medical College of Philadelphia, 1913; interned Methodist Hospital, Philadelphia, Pa., one year; EENT Hospital, New Orleans, La., Oct. 1, 1921-June 10, 1922; member Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; Past President of East Mississippi Medical Society; died Dec. 20, 1970, age 83.

DOSTER, JAMES THOMAS, III, Columbus. M.D., Tulane University School of Medicine, New Orleans, La., 1962; interned Charity Hospital, New Orleans, La., one year; ob-gyn residency Baylor University, Houston, Tex., July 1, 1963-June 30, 1966; died Dec. 23, 1970, age 33.

PATTERSON, CHARLES WHEELES, Rosedale. M.D., Tulane University School of Medicine, New Orleans, La., 1908; interned New York City Nursery & Children's Hospital, New York, one year; postgraduate Tulane in 1949; member Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; Past President of Delta Medical Society; Past Vice President of Mississippi State Medical Association; died Dec. 21, 1970, age 86.

VAN PELT, JAMES FRED, Gulfport. M.D., University College of Medicine, Richmond, Va., 1916; interned Chesapeake & Ohio Hospital, Huntington, W. Va., one year; postgraduate work Polyclinic, New York and University of Buffalo, New York; member Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; Past President Coast Counties Medical Society; died Dec. 1, 1970, age 76.

TWENTE, GEORGE E., Jackson. M.D., University of Illinois, Chicago, 1939. Internship and residency in general surgery, Barnes Hospital, St. Louis, Mo., 1939-1943. Major, U. S. Army Medical Corps, World War II. Diplomate, American Board of Surgery; Fellow, American College of Surgeons. Secretary-treasurer, MSMA, 1952-1959; chairman, Council on Legislation, 1954-59; chairman, Reorganization Commission, 1957-1958; Delegate to AMA, 1963-1966; member, AMA Council on Legislation, 1956-1960. Consultant in cardiac surgery, Mississippi Crippled Children's Service. Died Jan. 5, 1971, age 59.

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Glyceryl guaiacolate	100.0 mg.
Alcohol, 3.5%	

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Glyceryl guaiacolate	100.0 mg.
Pheniramine maleate	7.5 mg.
Codeine phosphate	10.0 mg.
(warning: may be habit forming)	
Alcohol, 3.5%	

Non-narcotic for 6-8 hr. cough control

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Each 5 cc. contains:

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Dextromethorphan hydrobromide	15.0 mg.
Alcohol, 1.4%	

Clears sinuses and nasal stuffiness as it relieves cough

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Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
Phenylephrine hydrochloride	10.0 mg.
Alcohol, 1.4%	

Robitussin-DM in solid form for "coughs on the go"

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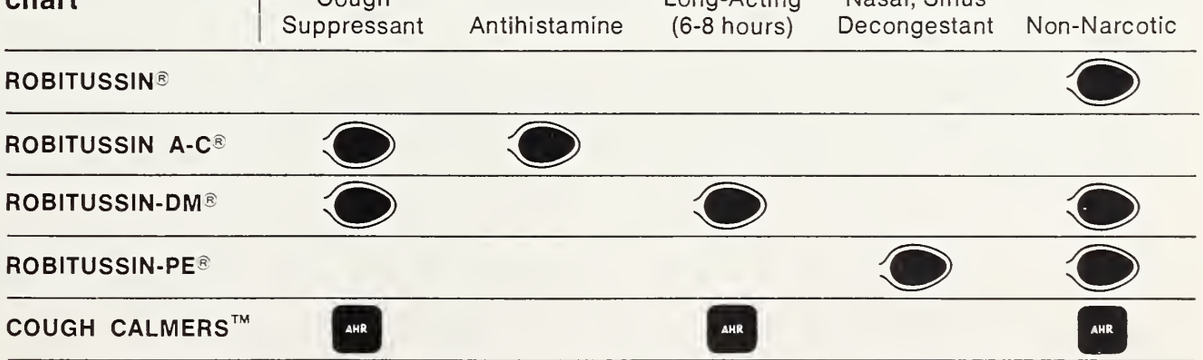
Each Cough Calmer contains:

Glyceryl guaiacolate	50.0 mg.
Dextromethorphan hydrobromide	7.5 mg.

Select the Robitussin® "Clear-Tract" Formulation That Treats Your Patient's Individual Coughing Needs:

Robitussin® extra benefit chart

All 5 Robitussins have an EXPECTORANT-DEMULCENT action. Keep this handy chart as a guide in selecting the formula that provides the *extra* benefits you want for your patient.



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Mental Health Association Meets

The annual meeting of the Hinds County Association for Mental Health had the theme, "Today's Youth in Today's World." The meeting featured a panel of young people and adults in a two-hour session in which the young people discussed problems as they see them and the adult participants reacted to these views. Dr. A. J. Comfort was the moderator.

The luncheon speaker was Dr. William Long of Jackson, whose practice is confined to adolescent medicine. His topic was "Focus on Upper Adolescents." Dr. Robert Mayo, president of the association, presided at the annual business session.

PERSONALS

HELEN B. BARNES and FRANK M. WIYGUL of Jackson took part in forums at the White House Conference on Children held in Washington, D. C. in December.

WILLARD A. BARNES, a native of Attala County, is now practicing medicine in Yazoo City at 110 South Mound Street.

MARGARET B. BATSON of Jackson and UMC was principal speaker at a special program held recently at Fair Elementary School. Dr. Batson spoke on the facilities available in Mississippi for diagnosis and treatment of learning disabilities in children.

WILDRED Q. COLE, JR., HENRY B. TYLER, and LOUIS A. FARBER, all of Jackson, have been named to the Board of Directors of River Hills Club.

JAMES S. FISACKERLY of Biloxi has been elected 1971 president of the Biloxi Business Men's Club.

R. H. FLOWERS announces the opening of his office for the practice of dermatology at Suite 8-10, 130 DeSoto Avenue in Clarksdale.

GEORGE C. HAMILTON, JR., of Jackson has been certified by the American Board of Psychiatry and Neurology.

JAMES D. HARDY of Jackson and UMC has been named recipient of the Capital City Sertoma Club's annual Service to Mankind Award.

VERNER S. HOLMES and LEWIS J. RUTLEDGE announce the opening of the Southwest Mississippi Ear, Nose and Throat Clinic at Brookway Plaza Shopping Center in Brookhaven.

BLANCHE LOCKARD and WILLIAM B. WIENER of Jackson announce the association of LEWIS D. LIPSCOMB in the practice of obstetrics and gynecology at 500-G East Woodrow Wilson Drive.

GILBERT R. MASON of Biloxi has been elected to active membership in the American Academy of Family Physicians, formerly the American Academy of General Practice.

ERIC MCVEY and DAVID VANLANDINGHAM of Jackson have been elected to the board of directors of Christian Youth Program, Inc., which sponsors Miracle House in Jackson. Miracle House is a counseling center for young people with problems.

A. J. MESSINA of Vicksburg has been named public health officer for Warren, Sharkey, Issaquena, and Claiborne Counties.

E. R. NORTH, JR., of Jackson has been elected director of the Southwest Horse Show Association.

W. J. PATTERSON of Jackson announces the removal of his office for family practice from Clinton Plaza Shopping Center to 650 Highway 80 West in the French Tile Building.

C. O. STANBACK of Columbus was guest speaker at the annual meeting of the North Mississippi Medical, Dental, Pharmaceutical and Nurses Society held in Columbus recently. JAMES H. NEELY of Tupelo presided.

The late RICHARD A. STREET, JR., of Vicksburg was honored posthumously with a resolution in tribute by the administrative board of Mercy Hospital-Street Memorial Hospitals.

PERRY K. THOMAS, JR., WALTER L. BOURLAND, and SWAN B. BURRIS of Tupelo announce the association of JOSEPH A. PRYOR for the practice of obstetrics and gynecology at 106 Thomas Building.

DAYTON E. WHITES of Lucedale has been elected to the Board of Directors of the newly organized First National Bank of Lucedale.

W. M. WOOD of Meridian was guest speaker for a recent Carthage Rotary Club meeting. Dr. Wood discussed community psychiatry and the community mental health programs.

Book Reviews

Insurance for the Doctor. By Harvey Sarner, LL.B., and Herbert C. Lassiter, LL.B. 193 pages. Philadelphia: W. B. Saunders Company, 1967. $9.00.

Assistance in planning and managing an insurance program which meets the personal and professional needs of the physician, is the objective of *Insurance for the Doctor.*

In 17 chapters, the various contracts of insurance are reviewed with emphasis on policy or contract provisions. A glossary of insurance terminology has been included to assist the reader. Specific examples of protection problems help the reader relate the various contract provisions to real situations both professional and personal.

In the final chapter, the authors set guidelines for the physician to use in selecting an insurance broker. Having read *Insurance for the Doctor,* the physician should be able to plan and manage his personal and professional insurance program, with the assistance of a qualified insurance broker.

THOMAS E. YATES, III

Atlas of Nuclear Medicine, Volume 2, Lung and Heart. By Frank H. Deland, M.D., and Henry N. Wagner, Jr., M.D. 284 pages with 810 illustrations. Philadelphia: W. B. Saunders Company, 1970. $20.00.

Nowadays it seems the objective of most writers in the field of nuclear medicine is to use such highly technical terminology that only truly serious students in the field can understand "what it's all about." Not so, this book. And, it is indeed refreshing to find a volume filled with useful information which is easy to comprehend.

The approach to the subjects at hand is straightforward. Few words are wasted on technical aspects of these procedures. The advantages and limitations of these studies are discussed, but not to the point of boredom.

Basically the book is, as the title states, an atlas, consisting of multiple case reports. Clinical information is presented with each case and is concise and pertinent.

Radiographs and scans used to demonstrate the case presentations are of excellent quality, as are line drawings used to simplify one's understanding of involved anatomy. Where applicable, arteriograms are presented to support the diagnosis.

The bulk of this volume is devoted to lung scanning and covers the subject extremely well. Particular emphasis is given to pulmonary embolism, and rightly so since it is in this condition that lung scanning is most useful. Good representative cases of other conditions affecting the pulmonary scan are also included, such as: congenital defects, tumors, obstructive lung disease, infectious diseases, trauma, congestive failure, and pleural effusion.

The final portion of this book discusses the application of scanning principles to the heart. Both rectilinear and camera scintiscans are presented in this section. Particularly interesting are the nuclear angiography studies included here. Again line drawings are freely used to emphasize these cases and where needed, contrast studies are included.

This book should prove to be a most useful addition to the library of all who are interested in these fields of medicine. It is not intended as a reference source (indeed, no references are included) but is rather a volume dealing with very practical problems relating to obtaining the maximum information available from pulmonary and cardiac scans.

T. S. MCCAY, M.D.

Drug Abuse Law Is Comprehensive

The Comprehensive Drug Abuse Prevention and Control Act of 1970 was signed into law in October by President Nixon. It attempts to create a balance between the authority of law enforcement and health officials and among law enforcement, health, and educational approaches to the problem of drug abuse.

The law has implications for the regional men-

tal health and mental retardation programs in Mississippi since it increases funding authorizations for facilities and services for the treatment of addicts and drug abusers for projects related to community mental health centers.

The law also provides for special HEW grants for treatment and rehabilitation projects, including a broad range of services, and includes provisions for HEW drug-abuse education project grants to state and local governments and to other public and non-profit agencies. Other provisions cover control and enforcement, and federal penalties for violations.

NEW MEMBERS

ALDRIDGE, JOHN EDWARD, JR., Jackson. Born Winona, Miss., Dec. 11, 1938; M.D. University of Mississippi School of Medicine, Jackson, Miss., 1964; interned University Medical Center, Jackson, Miss., one year; urology residency University Medical Center, Jackson, Miss., July 1, 1965-June 30, 1969; elected Nov. 3, 1970 by Central Medical Society.

BIGGS, JACK CLAYTON, Southaven. Born Memphis, Tenn., Jan. 13, 1927; M.D. University of Tennessee College of Medicine, Memphis, Tenn., 1963; interned St. Joseph's, Memphis, Tenn., one year; elected Dec. 11, 1970 by Desoto County Medical Society.

BERRY, SIDNEY RAY, Jackson. Born Shivers, Miss., Jan. 28, 1935; M.D. University of Tennessee College of Medicine, Memphis, Tenn., 1958; interned Fitzsimons General Hospital, Denver, Colo., one year; orthopedic surgery residency Brooke General Hospital, San Antonio, Tex. Oct. 1, 1959-Aug. 31, 1963; elected Sept. 1, 1970 by Central Medical Society.

HAYS, JAMES CLAY, Jackson. Born Greenville, Miss., Aug. 20, 1937; M.D. University of Mississippi School of Medicine, Jackson, Miss., 1962; interned University of Penn., one year; medicine fellowship Mayo Graduate School of Medicine, Rochester, Minn. Oct. 1963-Oct. 1966; cardiology fellowship University Medical Center, Jackson, Miss., Nov. 1968-June 1970; elected Sept. 1, 1970 by Central Medical Society.

New Nilcol- A Comprehensive Formula:

DESCRIPTION	Contents in mg Tablet	Elixir—each 15 ml
phenylpropanolamine HCl	50	25
chlorpheniramine maleate	4	2
glyceryl guaiacolate	200	100
dextromethorphan HBr	30	15
alcohol		10%

The scored, elliptical tablet is light violet. The elixir is deep violet in color and grape-flavored.

ACTIONS Each component of Nilcol has been selected to provide symptomatic relief of congestion and cough in upper respiratory disorders.

Phenylpropanolamine hydrochloride is a vasoconstrictor which reduces congestion of the nasopharyngeal mucosa. Chlorpheniramine maleate, a widely used antihistamine, helps to control allergic symptoms. The expectorant is glyceryl guaiacolate which helps to increase the secretion and decrease the viscosity of fluids of the respiratory tract. Dextromethorphan is a well-known, centrally acting antitussive. Nilcol may minimize the need for topical decongestants.

INDICATIONS Nilcol is indicated for nasal and bronchial congestion; coughs and other symptoms of respiratory infections including influenza and the common cold; other respiratory conditions such as sinusitis, allergic rhinitis or hay fever.

CONTRAINDICATION Hypersensitivity to any ingredient.

PRECAUTIONS Because of the possibility of drowsiness, patients should be cautioned against driving and operating machinery. Administer with caution to patients with hyperthyroidism, hypertensive cardiovascular disease, diabetes mellitus and liver disease. Use in pregnancy is not recommended.

ADVERSE REACTIONS Anxiety, restlessness, tension, insomnia, tremor, weakness, headache, vertigo, sweating, nausea, and vomiting may possibly occur.

SUPPLIED Tablets in bottles of 100. Elixir in bottles of 32 fl oz (1 qt) with dosage cups. N-GP-11-4C

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PATTERSON, WILFORD JOEL, Clinton. Born Sumrall, Miss., June 5, 1941; M.D. University of Mississippi School of Medicine, Jackson, Miss. 1968; interned same one year; cardiovascular fellowship same April 1, 1969-May 31, 1969; medicine residency same July 1, 1969-Sept. 30, 1970; elected Nov. 3, 1970 by Central Medical Society.

Howard Memorial Elects Staff

Dr. Warren Plauche of Biloxi has been elected president of Biloxi's Howard Memorial Hospital's medical staff. Dr. Frank Gruich was named chief of staff.

Others elected to the medical staff include: Drs. John O'Keefe, vice president; Irwin Joffe, secretary-treasurer; Jerry Adkins, chief of surgery; and Harry Schmidt, Sr., chief of internal medicine.

Dr. Steve Sekul was named chief of pediatrics and Dr. Robert Schmidt is the new chief of obstetrics. Dr. Eldon L. Bolton will serve as chief of general medicine.

Dr. Lee to Direct Mental Health Center

Dr. Mary Alice Lee has been named the director of the Jackson Mental Health Center serving the Jackson metropolitan area. The center, scheduled to open in early 1971, will be administered by St. Dominic's Hospital. Dr. Lee's appointment was announced by Sister Josephine Therese, administrator of the hospital.

Dr. Lee has been director of the Division of Mental Health Services of the State Board of Health since August of 1968 and before that was staff psychiatrist for the agency since 1964. She was a clinician at the Hinds County Health Department from 1957 to 1961 and took her residency in psychiatry at University Medical Center from 1961 to 1964.

Dr. Lee is a native of Waynesboro, and got her B.S. degree from the University of Alabama in 1953 and her M.D. degree at the University of Tennessee in Memphis in 1956. She is a member of the Mississippi Public Health Association, American Psychiatric Association, Mississippi Association for Mental Health and Hinds County Association for Mental Health, currently serving on its board of directors.

M.I.C. Named State's Drug Abuse Agency

The Mississippi Interagency Commission on Mental Illness and Mental Retardation has been designated as the state's administrative agency for drug-abuse programs.

Seth Hudspeth, M.I.C. chairman, said the designation by Gov. John Bell Williams "gives us a place to focus all the current interest in the drug-abuse problem."

He added: "It makes the M.I.C. the agency for planning a coordinated effort embracing all approaches to the drug-abuse problem in Mississippi, including education, prevention, treatment, rehabilitation, and liaison with law-enforcement agencies."

Each state is required to have a designated agency under the Comprehensive Drug Abuse Prevention and Control Act passed by Congress earlier this year and signed by President Nixon on Oct. 27.

Hudspeth said he had received a copy of a letter written by Gov. Williams to the Department of Health, Education and Welfare designating the M.I.C. as Mississippi's agency.

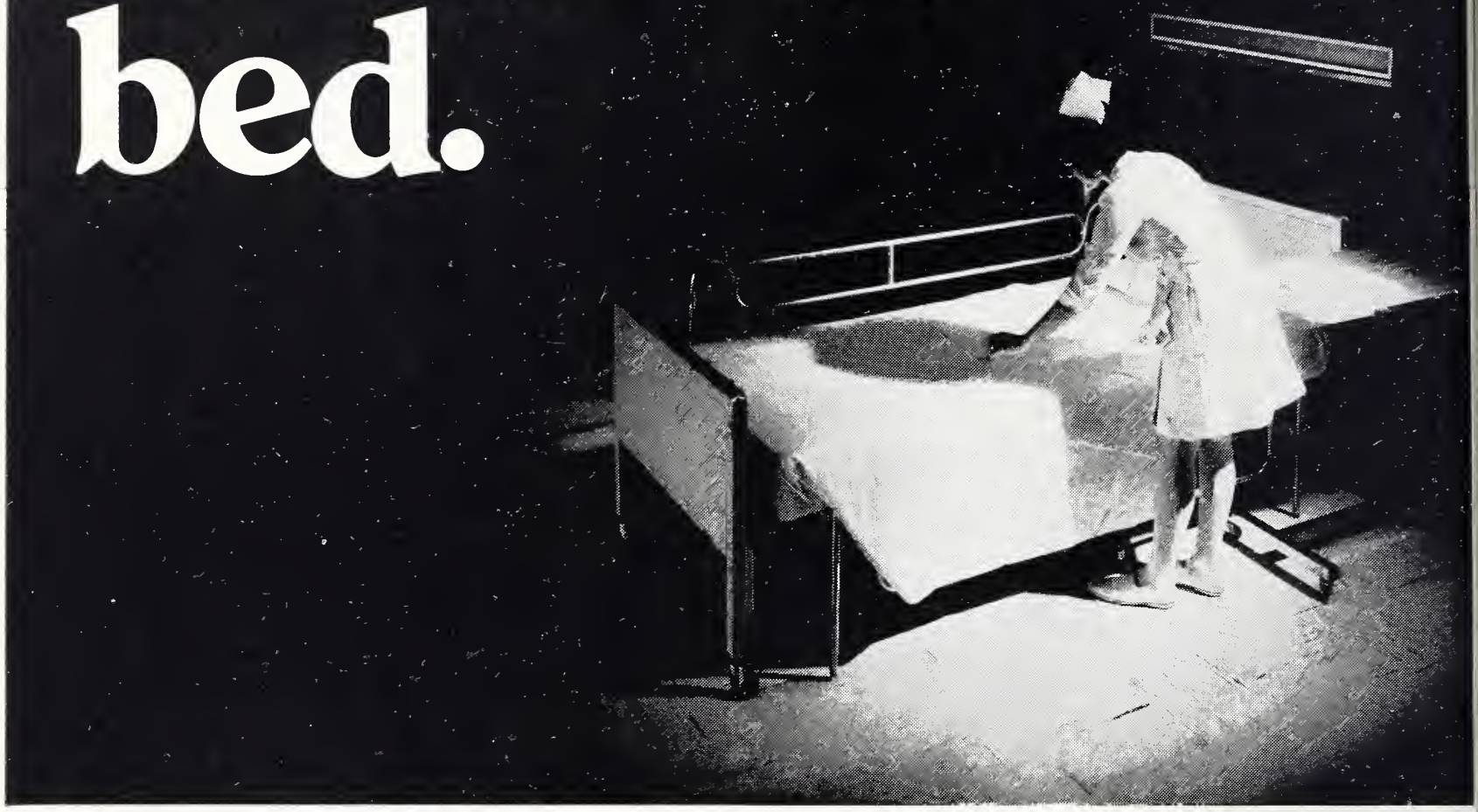
The 1970 act provides for grants from the National Institute for Mental Health for education, treatment and rehabilitation programs for drug-abuse. Designation of the M.I.C. means that applications for such grants filed from Mississippi must be reviewed by the M.I.C.

The M.I.C. is made up of the chief executive officers of the State Board of Health, Department of Education, Public Welfare Department, Board of Mental Institutions, and Board of Trustees of Institutions of Higher Learning.

It was established by the legislature as of July 1, 1966, and has spearheaded the development of regional mental health and mental retardation centers in the state. Dr. Dorothy N. Moore is M.I.C. program director.

Recently, the M.I.C. announced that over $4,000,000 in federal grants for building and staffing these regional centers have been approved since July 1, 1966, and that local matching funds and other funds make a total of $7,000,000 invested in Mississippi during that time in community programs for the mentally ill, mentally retarded, alcoholic and others behaviorally disturbed in some way.

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M.D.'s, Nurses, Pharmacists Join to Preserve State Public Health Structure

Three Mississippi associations in the health care field joined in a position statement on the sweeping reorganization proposal of the state's publicly supported health programs.

The Mississippi State Medical, Mississippi Nurses, and Mississippi State Pharmaceutical associations said that they oppose abolition of the State Board of Health, the combining into a single agency of licensure functions for health-related professions, and discontinuation of county health departments under a regionalization program.

The three organization presidents, Dr. Paul B. Brumby of Lexington, state medical association; Ann Zimmerman, R.N., of Hazlehurst, state nurses association; and William E. Farlow, R.Ph., of Jackson, state pharmaceutical association, released a joint statement on the Comprehensive Health Planning proposals immediately prior to the convening of the 1971 Regular Session of the legislature.

The proposals for sweeping organizational changes, contained in a study report prepared by Peat, Marwick, Mitchell and Co. for the Division of Comprehensive Health Planning, would centralize health programs of 30 operating entities into a single agency. The State Board of Health would be abolished in the move. (J.M.S.M.A. XI:615 (Nov.) 1970.)

"Since its inception in 1877, the State Board of Health has been nonpolitical," the presidents said.

"The governor appoints members from nominees named by peer professional groups, and the six year terms are so arranged that political pressures are absent. We support continuation of our State Board of Health as an identifiable, constitutional agency of the state."

The spokesmen said that combining licensure functions into a single administrative unit tended to remove this responsibility from peer groups under state law and control. The pending proposal states that national trends are toward single, multidisciplinary licensure agencies.

Under the plan, licensure records for physicians, dentists, nurses, pharmacists, and other allied professional personnel would be lumped under a single office. The study report appears to predict evolution of a single licensure board with multidiscipline makeup.

The professional groups also supported continuation of county health departments rather than consolidate them into multicounty regions requiring a pooling of county funds. The physicians, nurses, and pharmacists said that "county boards of supervisors and local health care providers would not exercise a sufficient voice under regionalization . . . and . . . most counties would apparently have to pay health funds into a regional pool under the recommendation."

The joint statement said that recommendations in the PMM report called for a restructuring of virtually all publicly supported health service functions in the state. Major feature of the proposal is creation of a single state agency.

Governing members of the super agency would consist of seven citizens appointed by the governor from among those of his own selection with members also appointed by the lieutenant governor and speaker of the House of Representatives. None of the commission members would be physicians or health professionals.

Dr. Brumby, Mrs. Zimmerman, and Mr. Farlow said that their respective organizations recognize that fragmentation, duplication, and some overlap exist among health-related agencies and their programs in the state.

"But," the presidents stressed, "the normal legislative process is a tried and proven method of correcting these problems in the interests of all Mississippians, and our associations will give their support in this endeavor."

Dr. Brumby said that the medical association's policy on the issue is "a carefully considered and scrupulously reviewed position." He said that studies were made by an *ad hoc* committee of the Council on Medical Service which met with officials of the Division of Comprehensive Health Planning to review the PMM study report.

The special committee was chaired by Dr. C. R. Jenkins of Laurel. His colleagues were Drs. John F. Lucas, Jr., of Greenwood, Jack A. Stokes of Pontotoc, and Bedford F. Floyd of Gulfport.

The Council on Medical Service received and approved the committee report, submitting it to the Board of Trustees who approved the position as association policy.

Association spokesmen said that the PMM proposals will be placed before the legislature during the current session. Sen. Hayden Campbell of Jackson, chairman of the Senate Public Health Committee, has expressed strong opposition to the proposals and has publicly declared himself in support of the constitutional independence of the State Board of Health.

The Mississippi Hospital Association has not yet fixed its position on the PMM proposals but is expected to do so when its officials meet at Jackson on Feb. 5. Prior to Christmas, MHA conducted a series of three regional meetings on the PMM study report to acquaint member institutions with the proposals for sweeping change.

The Mississippi Dental Association's Board of Trustees considered the PMM study report, but spokesmen for the association said that a policy position was not then taken.

Dr. Ross Honored in Hattiesburg

Mrs. Paul Waldoff of Hattiesburg has presented $5,000 to the Methodist Hospital there for decorating and furnishing a nurses' lounge in the hospital's planned expansion. The lounge is to be named after Dr. T. E. Ross, Jr. of Hattiesburg.

Mrs. Waldoff, in making the presentation to hospital administrator R. M. Castle, stated that she wished "to honor Dr. Ross, her personal physician for 40 years and a very dear and devoted friend for these many, many years."

The new three-story wing is scheduled for completion sometime in 1971, according to Castle.

Dr. Taylor Awarded 1970 Laurel Wreath

Dr. C. D. Taylor, Jr., of Pass Christian is the 1970 recipient of the Laurel Wreath, presented at the general meeting of the Biloxi, Gulport, Long Beach, and Pass Christian Chamber of Commerce.



Dr. Taylor

The award is given annually to a person who has made significant contributions to the Mississippi Coast community. Sponsored by Coast Federal Savings and Loan Association, the Laurel Wreath was presented by Rob Barber, secretary-manager of the association. A panel of anonymous judges selected Dr. Taylor from among persons nominated by the general public.

"In the aftermath of Hurricane Camille, Dr. Taylor worked endless hours above and beyond the call of duty to bring emergency medical care to his devastated community. Surpassing his duty as a doctor, he also served as an inspired civic leader who was a source of strength.

"At an hour of crisis, when his community was virtually destroyed, Dr. Taylor served valiantly to preserve Pass Christian's morale. As a prime example of perseverance in the face of disaster, he became a rallying point in recovery efforts," Mr. Barber stated.

Dr. Taylor has served twice as chief of staff of Memorial Hospital in 1956 and 1970. He is a delegate of the Mississippi State Medical Association and past president of the Coast Counties Medical Society. For nine years he has been a member of the MSMA executive committee and board of trustees and is a past president of the Coast Clinical Society.

He was elected Pass Christian's most outstanding citizen in 1956. Dr. Taylor is a member of the board of directors of Hancock Bank, official physician for Harrison County, chairman of the Pass Christian Housing Authority. He has served as warden and vestryman of Trinity Episcopal Church and president of the West Harrison County Development Association.

A native of Pass Christian, Dr. Taylor received his M.D. degree from Tulane University School of Medicine.

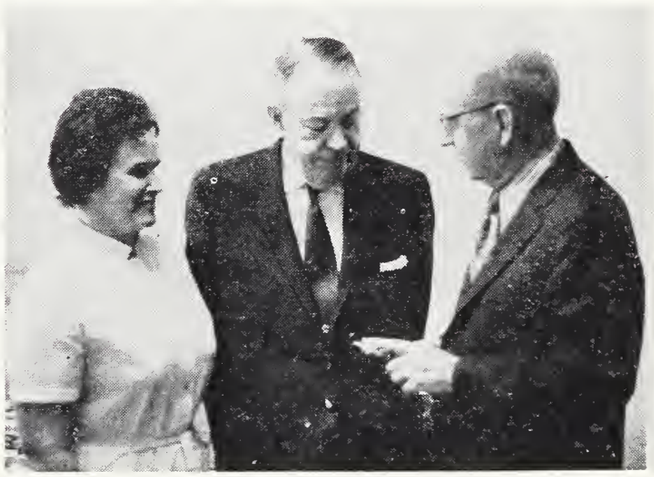
Alcoholism Committee Gains Five Members

Secretary of Health, Education, and Welfare Elliot L. Richardson has announced the appointment of four new members and the reappointment of one member to the National Advisory Committee on Alcoholism.

The new members are Dr. Dale Henry Farabee, Commissioner of the Kentucky Department of Mental Health; George Herrmann, III, Chairman of the Advisory Board of the Section on Alcoholism Programs, Illinois Department of Mental Health; David J. Pittman, Ph.D., Director of the Alcoholism Education Program and the Social Science Institute, Washington University, St. Louis, Mo.; and Dr. Maxwell N. Weisman, Director of the Maryland State Division of Alcoholism Control, Department of Mental Hygiene. Mrs. Marty Mann, executive director of the National Council on Alcoholism, has been reappointed to the committee.

The National Advisory Committee on Alcoholism was created in October 1966, to provide the Department of Health, Education, and Welfare with advice and guidance concerning the DHEW role in reducing the incidence of alcoholism and the other problems of alcohol use and abuse.

EMCU Opens to Serve Legislators



Senator Hayden Campbell of Jackson, chairman of the senate public health committee, center, confers with Dr. Paul B. Brumby of Lexington, president of the Mississippi State Medical Association, at the emergency medical care unit maintained at the Capitol by the association for members of the legislature. Mavis Barlow, R.N., of Jackson, assists the "doctor of the day" in the service project.

—The lowest priced tetracycline—nystatin combination available—



Anderson Papers Given to Archives Department

The papers of the late Dr. W. H. Anderson, Booneville surgeon, editor and civic leader, were recently presented by Mrs. Anderson to the State Department of Archives and History in the War Memorial Building.

Dr. R. A. McLemore, Director of the Department, accepted the papers from Mrs. Anderson, who donated them at the request of the Department's Board of Trustees. The papers will be known as the W. H. Anderson Collection, and according to McLemore, will be a valuable source of Mississippi medical, social and cultural history over a period of more than 70 years.

Dr. Anderson served for many years as chief of staff, Anderson's Clinic, Booneville, and was former health officer of Prentiss County, editor of *The Mississippi Doctor,* an official publication of the Mississippi State Medical Association, editor of the *Booneville Independent,* weekly newspaper, and former president of the Mississippi State Medical Association. Dr. Anderson died May 9, 1969.



Dr. R. A. McLemore, director of the State Department of Archives and History, accepts the papers of the late Dr. W. H. Anderson, prominent Booneville surgeon and civic leader, from Mrs. Anderson.

RMP Holds Program Retreat

Nearly 50 Regional Advisory Group and Planning Committee members, core staff and guests met in Biloxi for the first Mississippi Regional Medical Program retreat.

Aim of the workshop was to define MRMP's program priorities and evaluate their relation to Mississippi health needs. The crucial instate manpower deficiency heads the roster, with emphasis on more, innovative types of health workers, maximum utilization of time and statewide cooperation of related agencies.

A second major consideration is the design of current and proposed health care systems to determine the most effective health care delivery, tailored to the public's needs and in the light of various health care payment mechanisms.

Continuing education for the entire health team is basic to the success of both top MRMP goals, stressed workshop participants. Other MRMP priorities include public education, both through local power structures to stimulate community action and schools for health education and a relook at MRMP organization and structure.

Guest speaker Robert Lawson, deputy director, Tri-State Regional Medical Program, Boston, Mass., outlined RAG responsibilities and presented an overall look at review process, an effort to decentralize grant authority from the nucleus Regional Medical Program Services to local regions.

Regional Advisory Group chairman Dr. Lewis Nobles, Mississippi College president, named a four-man RAG executive committee, made up of W. O. Stanley of Jackson, Mississippi director, Communications Workers of America; Dr. Stephen Moore of Jackson, director, Office of Comprehensive Health Planning; S. D. Craig of Jackson, director, Mississippi Farm Bureau; and Dr. Cyril Walwyn of Yazoo City.

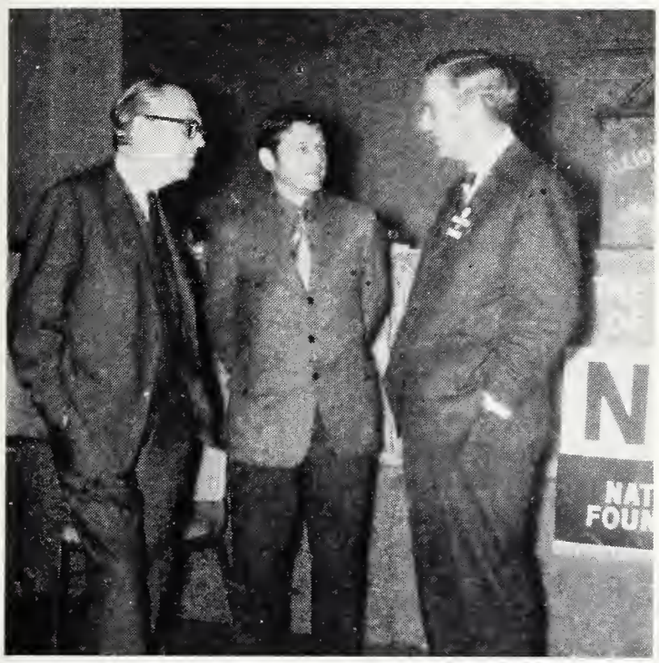
New RAG members are University Hospital director D. Andrew Grimes of Jackson; Mississippi Economic Council president Taylor Webb of Leland; Operation Shoestring director Mrs. Nancy Gilbert of Jackson; Choctaw Tribe vice-president Frank Henry of Neshoba; Jackson V. A. Center administrator John Byrd of Jackson; Dr. John P. Elliott, Jr., of Tupelo; St. Francis Church administrator the Rev. Malcolm O'Leary of Yazoo City; and Harold Whitaker of Jackson, Mississippi State Board of Health.

Concluding the business meeting, both MRMP committees jointly urged strong support for the Senate-recommended RMPS appropriation from

Mississippi U. S. Senators John Stennis and James O. Eastland.

March of Dimes Luncheon Held

The Annual March of Dimes Kick-Off Luncheon was held in Jackson in December. Featured speaker was Dr. Frank A. Rose, a native of Meridian and now head of Planning and Development at the Salk Institute.



Dr. Frank A. Rose, at right, head of Planning and Development at the Salk Institute, confers with Dr. Blair Batson, left, professor of pediatrics and chairman of the UMC department, and Dr. John R. Jackson of Hattiesburg.

Another key participant was Dr. John R. Jackson of Hattiesburg. The Hattiesburg pediatrician has served as medical advisor to the Forrest County March of Dimes chapter for the last three years. He is consulted by the chapter regarding patients with birth defects and when necessary, refers them to the Birth Defects Center at the University of Mississippi Medical Center in Jackson, one of a network of 110 such centers supported by the March of Dimes throughout the country.

UMC Plans OB Technician Program

A new obstetrical technician training program, beginning in the fall, 1971, at the University Medical Center, promises much-needed aid for Mississippi obstetricians.

Following the lead of many university medical centers across the nation, the nine-month course will teach nonprofessionals to perform specific duties to conserve the time of highly trained professionals.

Graduates of the nine-month ob technician training program will assume definite responsibilities in the labor, delivery, postpartum and obstetrical operating rooms, as well as in maternal clinics, working under an R.N.'s supervision.

The University of Mississippi School of Medicine obstetrics and gynecology department and the Office of Allied Health Professions jointly developed the course, with the cooperation of the Division of Adult Education. Funds supporting the training program are available through the Manpower Development Training Act and Health Services and Mental Health Administration contracts.

Tri-State Thoracic Society Meets

Chest specialists from Mississippi, Alabama and Louisiana met in Biloxi at the Buena Vista Hotel on Jan. 8-9, for the 15th Annual Tri-State Thoracic Society Consecutive Case Conference. Dr. Antone Tannehill, Jr., of Tupelo, president, presided.

This special scientific meeting was co-sponsored by the Thoracic Societies and Tuberculosis and Respiratory Disease Associations of Mississippi, Alabama and Louisiana.

Members of the Mississippi Thoracic Society featured on the program during the two-day session include Drs. Guy Campbell, Roland B. Robertson, Karl Stauss, all of Jackson, and Dwight Keady, Sanatorium. Dr. Boyd Shaw, Jackson, served as moderator for one of the three scientific sessions.

Guest discussants at the two-day conference were: Dr. Averial A. Liebow, La Jolla, Calif.; Dr. William D. Logan, Jr., Atlanta; and Dr. John McClement, New York City.

Other program participants included: Drs. Merril Bradley, Felix Henley, Bayard Tynes, Birmingham; Dr. Tuncay Ehrtan, Alexandria, La. and Dr. Robert Dillenkoffer, New Orleans.

Topics for discussion included open lung biopsy, resection of atypical AFB, percutaneous lung biopsy, tuberculosis in a general hospital, aspects of lung pathology, sarcoid and interesting pulmonary angiograms.

MSBH Tuberculosis Control Unit Acts

The 240 pound six-foot-four football player was diagnosed as a "very active contagious pulmonary tuberculosis" case.

It was a diagnosis that alarmed the parents of other pupils in the Union High School—first graders through twelfth graders.

The State Sanatorium's diagnosis was received in Union on Monday morning.

Public Health Nurse Lucile Doolittle immediately put in a call for the Tuberculosis Control Unit at the State Board of Health in Jackson.

Supervisor Wayne Early was in his office, and at 8:30 o'clock the next morning a team from the State Board of Health was on the scene with Ped-O-Jet tuberculin testing guns in action and a mobile x-ray unit standing by.

"Mrs. Doolittle knew that no time should be lost, but she didn't know that we could swing into action so quickly," said Early, the week afterward.

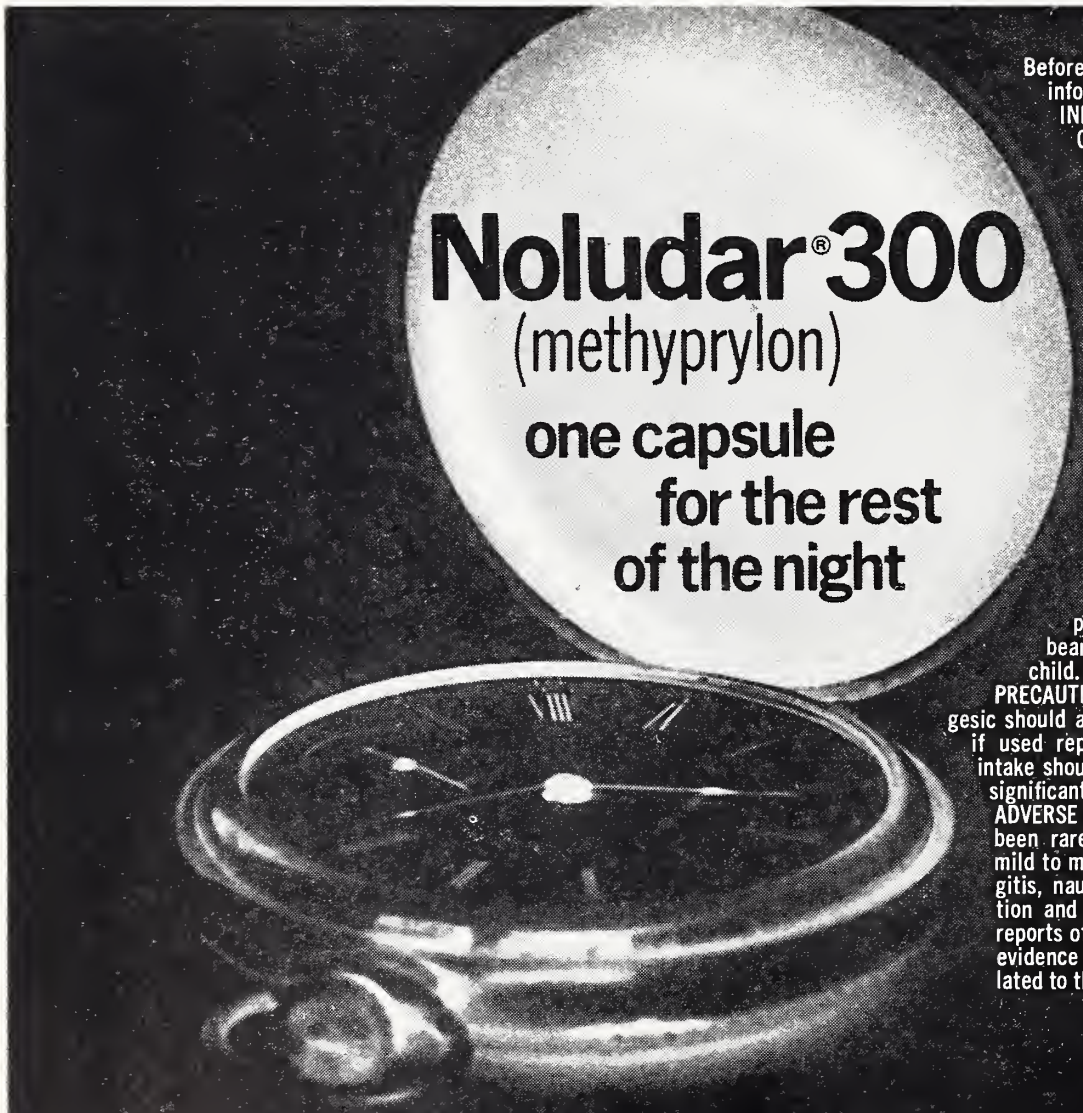
"When she called us, we told her to make contact with the school and alert the community to the importance of skin testing. We called the four industries in the area and made arrangements to screen their personnel. We knew that eight adults in the district had been diagnosed as tubercular in the last five months, working people, parents of school-age children."

"Our little paper comes out once a week, on Thursday. We have no radio. So I just got in my car and headed toward town. I stopped at one house in every block and told the people to get the word around," explained Mrs. Doolittle.

On Tuesday and Wednesday as skin testing went forward at the school, the Community Center and the four plants, radio station WBKN in nearby Newton and WTOK-TV in Meridian, on the hour, urged the residents in the Union school district to cooperate with the public health program in progress.

And the people responded! A total of 2,062 skin tests were made and 493 x-rays taken.

On Thursday and Friday, skin tests were read and positive reactors were x-rayed. Each of the 82 reactors was given a sack containing a 3-month supply of preventive drugs, leaflets on tuberculosis and its control, as well as an individual word-of-mouth explanation of the necessity of taking the drugs.



Before prescribing, please consult complete product information, a summary of which follows:
INDICATION: Relief of insomnia of varied etiology.
CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.
Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.
Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.
PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.
ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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"Before the week was over I must have talked to over 3,000 people twice over," said Mrs. Doolittle.

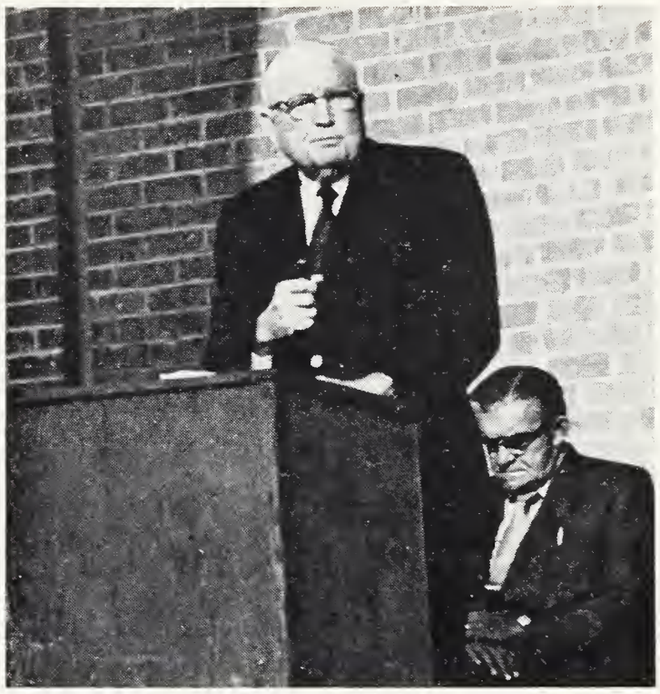
When asked how the reactors accepted the idea of medication, she said: "One of the bosses in one of the plants came up with a positive. That did it! Everyone accepted medication like candy."

Clerk for the program was Mrs. Betty Henry, of Union, the health department clerk-typist. Serving on the MSBH team with Early were Special Investigators Ken Harris of Laurel, Dewey Harmon of Meridian and Garry Pace of Jackson.

"Public health in action was demonstrated in those four days in Union," said Supervisor Early. "It was a team effort—local and state public health personnel supported by private physicians, school administrators, industry and news media.

"TCU is here to help," said Early. "When there's a newly reported case of TB, if a county will holler for us, we'll come.

"Schedules are hard to make and we don't like to break them, but we'll abandon a schedule anytime to get on top of a newly reported case."



Senator James O. Eastland makes the dedicatory address as the 50-bed Calhoun County Hospital was dedicated at Bruce. On hand for the ceremonies was Mayor W. H. Thompson (left) of Bruce.

Sen. Eastland Speaks at Hospital Dedication

"The nation must match its technological advances 'with equal strides in the field of medicine' if it is to maintain its bright future," said Senator James O. Eastland (D-Miss.) at the dedication of the new 50-bed Calhoun County Hospital in Bruce recently. Eastland said progress in health facilities and medical care must match growth in agricultural, industrial, commercial and educational activity.

"If we do not keep pace," said the Senator, "we will suffer the penalty of failure to achieve the balance necessary to the rapid growth of Mississippi and the well-being of her citizenry."

Eastland delivered the major address at the dedication which was attended by more than 1,000 guests. Dr. O. B. Crocker, Sr., a long-time friend of Eastland, is administrator of the facility.

The Mississippi lawmaker pointed out that industrial growth is dependent on good medical facilities. "Early in discussions of plant sites, raw material and labor availability, the question of hospital facilities always arises," he said.

"My point is that industrial expansion and new jobs are linked directly to our capability to provide top quality health care to the businesses we are inviting to our state."

Eastland said the health of the nation is the key to its future. "Our strength in every corner of our country can be no greater than the health and vitality of our population," he added.

The Senator labeled the new facility "one of the finest" in the state. "It will save lives and alleviate suffering," he said. "It will serve the people through many tomorrows, and, thusly, serve our state and our nation."

Eastland had high praise for the family physician, calling him a "common pillar" around which many communities have been built. "This healer of the sick, adviser to families and leader in community affairs has held the honored title of country doctor—loved and respected by the millions of his fellowmen whom he served in the past and the present."

He called the state's physicians and nurses "soldiers in an old and honored army—the army of healers"—and added, "we can take pride in the tremendous contributions to the march of medicine which have been made by doctors from our section of this country."

He praised doctors who have not restricted their talents to the practice of medicine. "They have given freely of their leadership abilities in public and private endeavors," he said. "Brighter lives for their neighbors, stronger states and a better country testify to the results of their labors."

Dr. Crocker and his son, Dr. Charles Crocker, a surgeon, will have offices in the front wing of the new facility.

Col. Crozier Receives 28th Gorgas Medal

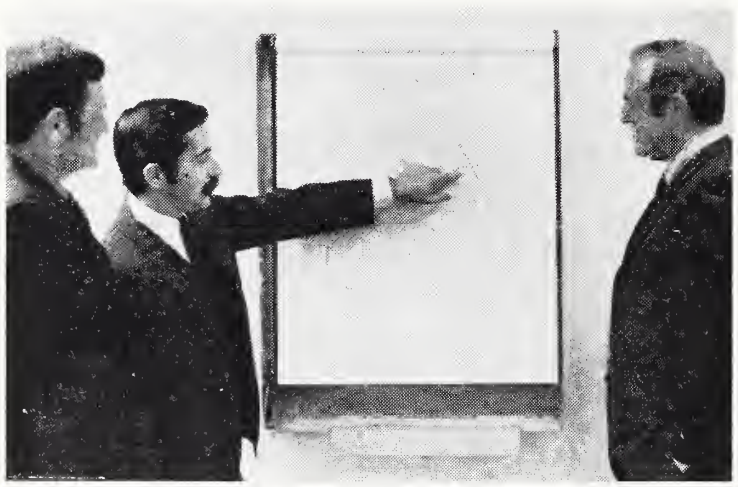
Colonel Dan Crozier, commanding officer of the U. S. Army Medical Research Institute of Infectious Diseases, Fort Detrick, has been awarded the 28th Annual Gorgas Medal.

The Medal, with a citation and an honorarium, was presented by the Association of Military Surgeons of the United States at their annual meeting at the Washington Hilton Hotel. Dr. George E. Farrar, Jr., represented Wyeth Laboratories, sponsors of the Medal, at the presentation.

The citation honors Col. Crozier for his "noteworthy scientific contributions to the understanding of infectious disease processes and the development and testing of vaccines," and for his leadership "in the development of this nation's present medical defensive posture against the threat of bacteriological warfare."

The citation notes, "In this continuing effort, Col. Crozier has envisioned and directed a broad research program concerned with medical defense measures. This program requires extensive coordination of military, academic and industrial capabilities.

Pharmacists Plan Drug Conference



Shown planning a conference for physicians and pharmacists are (from left to right) Kerby E. Ladner, program coordinator, Dr. Mickey C. Smith, program moderator, and Joe B. McCaskill, Acting Dean of the School of Pharmacy.

The University of Mississippi School of Pharmacy will sponsor a joint conference for physicians and pharmacists at Jackson on Feb. 9.

The conference will cover problems of drug interaction in medical practice and will convene at 5 p.m. at Primos' Northgate Restaurant.

Dr. Mickey C. Smith is program moderator and Kerby E. Ladner is program coordinator. Among the panelists is Dr. Robert Tyson of Jackson.

Interested physicians are urged to send advance registration fees to the Bureau of Pharmaceutical Services, University, Mississippi 38677. Fee for the conference, which includes a reception and dinner, is $10.00.

UMC Announces Personnel Changes

The Board of Trustees, Institutions of Higher Learning, approved some seven faculty and administrative changes at the University of Mississippi Medical Center in December.

Dr. Nenad Grcevic and Paul Curtis Woosley are both new appointments in the School of Medicine. Dr. Grcevic, chairman of the neuropathology department at the University of Zagreb, Yugoslavia, is a visiting professor of pathology for a four-month session through March, 1971. Dr. Grcevic, who earned the M.D. degree at Medical Faculty, Zagreb, Yugoslavia, was also a UMC visiting professor in 1968.

A preventive medicine instructor, Woosley holds an M.S. from the University of Minnesota.

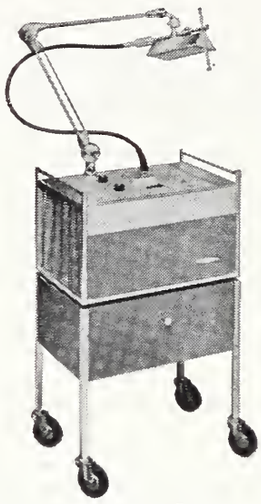
Dr. Herbert Langford, professor of medicine, was promoted from associate professor to professor of physiology and biophysics in addition to his other duties.

Former Mississippi Regional Medical Program director Dr. Theodore D. Lampton succeeded Dr. Guy D. Campbell as MRMP coordinator Jan. 1. Dr. Campbell returned full-time to the V.A. but retains his appointment as associate professor of medicine.

Pat Gilliland joined the MRMP staff as assistant director. Prior to his appointment, Gilliland was Medical Center personnel director, a post now held by former personnel assistant Lynn Ross.

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IN CONCLUSION

University of Tennessee medical alumni can properly swell with pride over rare and unprecedented honors coming to three prominent graduates in mid-January. Three UT physicians received promotions to major general in Army Medical Corps on the same day. They are Spurgeon Neel, deputy surgeon general of Army; Carl Hughes, former acting commander of Walter Reed Medical Center; and Colin F. Vorder Bruegge, new Walter Reed commander.

American College of Apothecaries' weekly newsletter, Voice of the Pharmacist literally takes the pants off physicians and American Medical Association. Recent issues score AMA for "failure" to rank pharmacist as the true drug expert with inference that M.D.'s lack understanding of pharmacology. Voice also beats drums for a third class of drugs which would be available only in a pharmacy and sold only under a pharmacist's supervision.

President Nixon, now 58, is probably the healthiest chief executive since Herbert Hoover. He is in the pink with 118/82 blood pressure, a nonsmoker, and no disease condition. FDR was a polio cripple; Harry Truman, a hypertensive; Eisenhower was bugged with cardiac problems, bad stomach, and stroke; JFK had Addison's which might have killed him in second term if he had lived; and LBJ suffered heart attacks and gall bladder troubles.

New University of Nevada School of Medicine announced its first class of 24 who will begin classes next September. In 1972, the new two-year school will admit 36, and beginning classes will be 48 per year in 1973 and thereafter. A new record for applications may have been established with 1,000 seeking the 24 places in first class. Beginning students are mature with ages ranging up to 28 years, and all but one are Nevada or Utah university graduates.

A 26-minute sound-slide documentary on chiropractic quackery is available from AMA Department of Program Services. This audio-visual is especially valuable for service clubs, schools, and church groups and also appropriate for hospital staff meetings to sharpen M.D.'s for discussions with legislators. Write AMA, 535 N. Dearborn, Chicago 60610, for documentary. Equipment needed is slide projector and cassette player.

Volume XII
Number 3
March 1971



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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The Journal of the Mississippi State Medical Association is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $7.50 per annum; $1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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Medical Organization **139** New Sheraton-Biloxi for 103rd Annual Session

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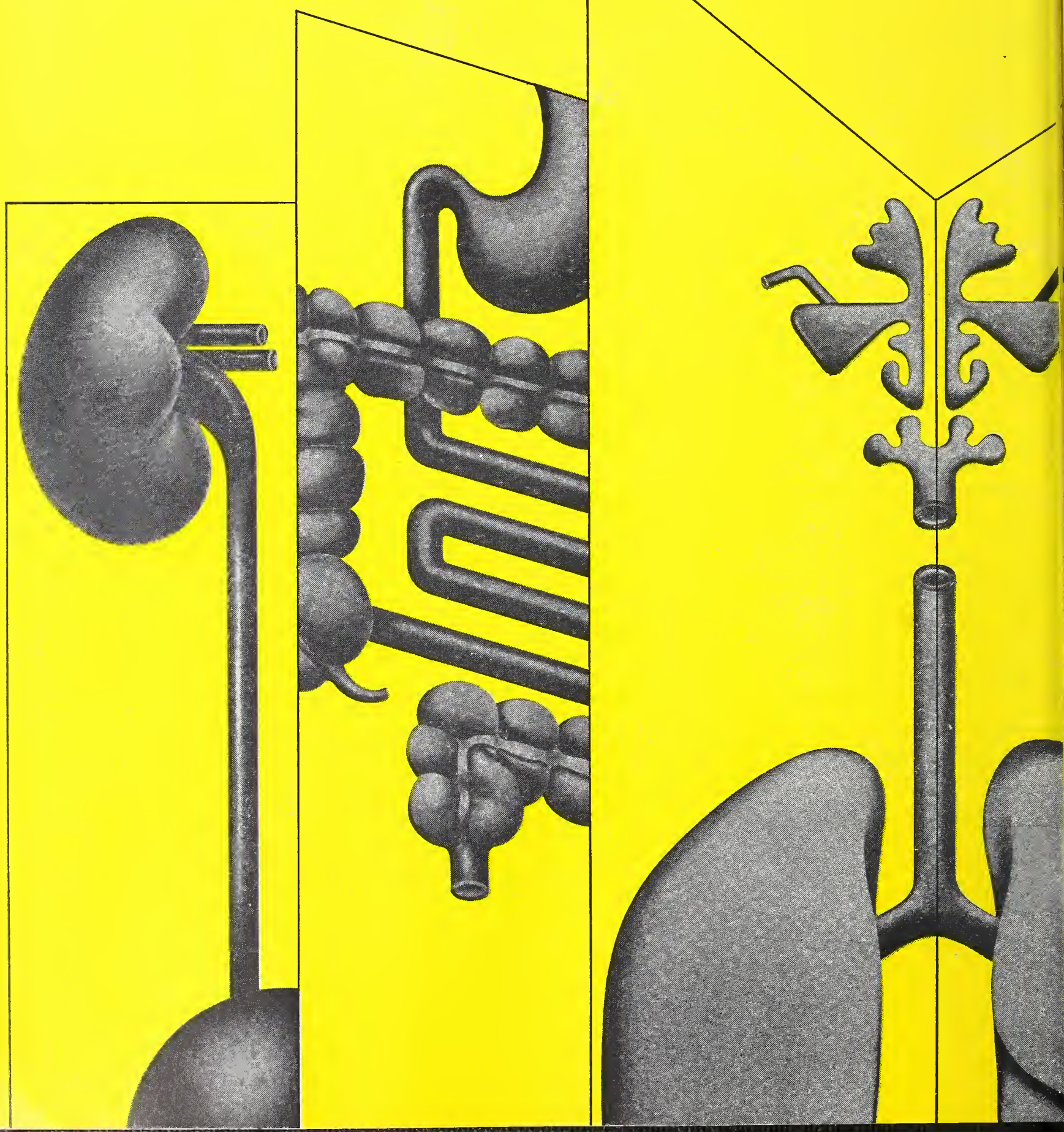
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Precautions: Mycotic or bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. Cases of gonorrhea with a suspected primary lesion of syphilis should have darkfield examinations before receiving treatment. In all other cases where concomitant syphilis is suspected, monthly serological tests should be performed for a minimum of 4 months.

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Southeastern Surgical Congress to Meet

The Southeastern Surgical Congress will hold its 39th annual assembly April 19-22 at the Americana Hotel in Miami Beach, Fla.

The four-day program will consist of guest speakers, president's panels, movies, round table luncheons, and a forum on progress in surgery.

The Distinguished Service Award, highest award of the Southeastern Surgical Congress, will go to Dr. Murray M. Copeland, professor of surgery at the University of Texas M. D. Anderson Hospital and Tumor Institute, Houston.

Registration fee for visitors is $25. There is no fee for congress members, residents, interns, and armed forces physicians in uniform.

An abbreviated program for nurses will be held concomitant with the congress.

Plastic Surgery Pamphlet Answers Questions

A new eight-page pamphlet, "Facts About Plastic Surgery of the Nose," has been published by the American Academy of Facial Plastic and Reconstructive Surgery, Inc.

The pamphlet was prepared to familiarize patients with the facts about plastic surgery prior to discussion of individual problems. Despite the more than 500,000 people who annually undergo surgery to improve their appearances or to correct congenital or accidental deformities, little is generally known about this most common form of plastic surgery.

The pocket-sized booklet lists important prerequisites and, especially, the sense of realism and emotional maturity patients should have when approaching nasal surgery. In factual and easily-understood language, the patient is cautioned that everyone is not necessarily a good candidate for such surgery and not every patient is accepted for an operation.

In a brief, but comprehensive outline, surgical and postoperative procedures are outlined to provide a complete picture of what the patient should expect.

Sample copies of the brochure are available from The American Academy of Facial Plastic and Reconstructive Surgery, Inc., 1110 W. Main Street, Durham, N. C. 27701.



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NEWSLETTER

March 1971

ear Doctor:

ississippi physicians are becoming increasingly disenchanted with edicare because of stingy payments and layer-on-layer bureaucracy. ecent rash of M.D. protests is over refusal of carrier, Travelers nsurance Co., to pay $5 for office visits, despite fact that sub- itting physicians have long charged such a modest fee. Situation s often worse with internists' services, many charge.

> Nursing homes are faring poorly under both Medicare and Medicaid with claim denial a rule rather than exception. American Nursing Home Association has withdrawn approval of programs and has urged its 6,000 member institutions to do likewise.

niversity of Alabama at Birmingham will soon have the most modern edical center complex of hospital facilities in the nation. Work as begun on $36 million, four-tower addition to be dedicated to eart disease, cancer, diabetes, and self-care. With modernization f present UA hospital, complex will have 900 beds. Another $16 illion in construction is for new basic science center.

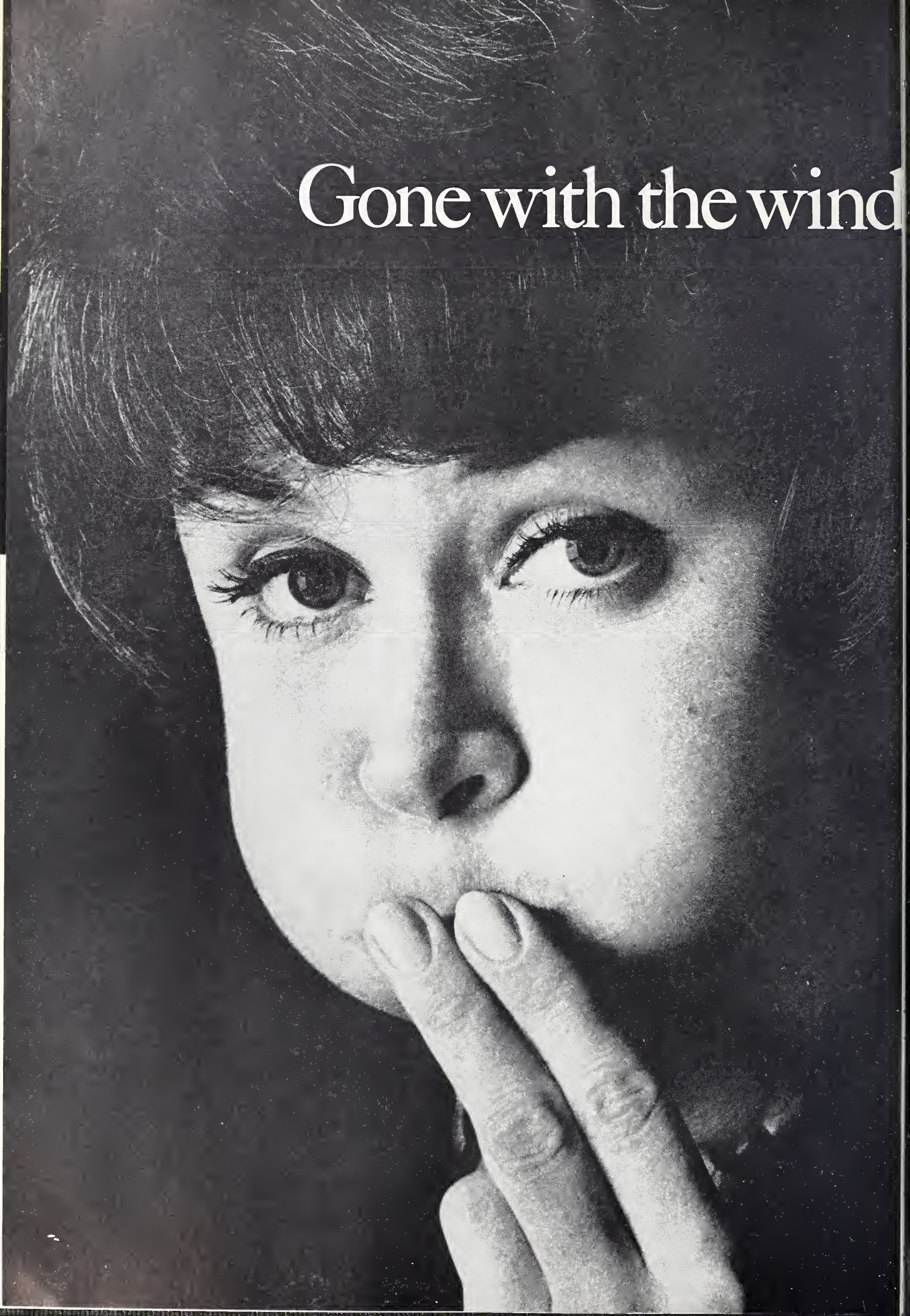
wo major midwest medical associations, Illinois and Iowa, have stablished statewide medical care foundations. Both wholly-owned orporations will conduct physician-sponsored peer review, act as iscal administrators for medical care plans, and serve as buffers etween practitioners and third parties, especially government. oth foundations assure full local society autonomy in decisions.

he Neshoba County General Hospital at Philadelphia shook things up ith fiat that Negro Medicare patients will be made to deposit $250. ospital said that no Medicare patient had ever been refused admis- ion but that it cannot absorb difference between costs and Medicare eimbursements. Provision, applying only to blacks, drew fire from ederal government officials and civil rights groups.

econd and final billing for 1971 dues is being sent to members who ave not yet paid. Number is small, however, because response to ew one-check, tax-record billing service has produced best member- hip yet. Active members who have not paid by April 1, according to y-Laws, must be dropped from rolls. Local societies handle reports or Emeritus and other exempt members.

Sincerely,

Rowland B. Kennedy
Executive Secretary


Gone with the wind

AHA Sets Abstracts and Exhibits Deadline

Abstracts of papers and applications for cardiovascular films and scientific exhibits to be presented at the American Heart Association's 44th annual scientific sessions must be postmarked by June 4, 1971. The meeting is scheduled for the Convention Center in Anaheim, Calif. Nov. 11-14.

Papers intended for presentation must be based on original investigations in the cardiovascular or related fields. The project's results and the investigator's conclusions should be summarized in the abstract and must be submitted on official AHA forms.

New cardiovascular films will be shown concurrently with the scientific sessions. The association's subcommittee on films will select prints to be presented.

Official forms for submitting abstracts, films and scientific exhibits may be obtained from AHA's department of medical education, 44 E. 23rd St., New York, N. Y. 10010.

ACP Holds La.-Miss. Meet

The American College of Physicians (ACP) will hold a scientific meeting for specialists in internal medicine and related specialties March 5-6 in New Orleans, La.

The Louisiana/Mississippi area meeting is one of 37 state/area meetings the College has been sponsoring during the 1970-71 academic year. Held throughout the United States and Canada, the meetings are helping internists and specialists in related fields to keep informed of developments in the basic and clinical sciences that affect their practices. The College has been holding these scientific-educational meetings annually since 1930.

The Louisiana/Mississippi meeting is under the general direction of Dr. A. Seldon Mann, New Orleans, ACP Governor for Louisiana, assisted by Dr. Wesley W. Lake, Sr., Gulfport, Miss., ACP Governor for Mississippi. Dr. Mann is professor of clinical medicine at Tulane University School of Medicine and Dr. Lake is assistant clinical professor of medicine at Tulane.

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Chicago Society Sets 27th Annual Conference

An exciting and varied program geared to the needs of the physician or surgeon has been planned for the 27th annual Midwest Clinical Conference of the Chicago Medical Society. The meeting, set for March 3-6, will be held at the new McCormick Place. It is expected to draw 4,000 medical leaders representing virtually every segment of the profession.

"Reflecting the varied needs of its members, the Society has planned a broad program of lectures, instructional sessions, films, and sessions on socio-economic issues," said Dr. John M. Dorsey, chairman of the Clinical Conference Executive Committee. The program has been planned and arranged through the cooperation of several allied medical organizations, including the Chicago Pediatrics Society, the Chicago Anesthesiology Society, the Chicago Surgical Society, the Chicago Society of Plastic Surgeons, the Illinois Chapter of the American College of Chest Physicians, and the Trauma Committee of the American College of Surgeons. The lecture program has been completed by Dr. Robert Carton.

Among the highlights of the four-day program are: an all-day session entitled, "Crisis in the Emergency Room," arranged by Dr. Sam Banks, of the Trauma Committee of the American College of Surgeons; several instructional courses in the areas of internal medicine, surgery, and obstetrics and gynecology, arranged through the services of Dr. Phillip Freedman, professor and chairman, Department of Medicine, Chicago Medical School; Dr. Robert Freeark, chairman, Department of Surgery, Loyola University Stritch School of Medicine; and Dr. John G. Masterson, vice president for the Medical Center, Loyola University Stritch School of Medicine; a special session on alternatives to the pill, surgery and abortion; a panel on non-cancerous problems of the breast, programmed by the Chicago Society of Plastic Surgery; a panel discussion of "Drugs—Problems of Behavior" arranged through the services of Dr. Leroy P. Levitt, dean of Chicago Medical School.

In addition, there will be sessions on practice management, money management, and parliamentary procedure. Running concurrently with the various sessions will be a specially selected series of recent films on medical subjects, arranged by Dr. John M. Beal.

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DATELINE

stage Rate Hike ll Hit M.D.'s

Washington - Look for the 8 cent first class letter, the 11 cent air mail, and the 6 cent post card by May. Reorganized, semi-corporate stal system can now raise rates without Congressional action and ll do so to wipe out $1 billion annual deficit. Costs to M.D.'s ll be noticed, and big mailers of low money unit statements will hit hard. Postage increase will hit all classes of mail except rcel post and generally continues to subsidize junk mail.

ltists Sue ah Blue Shield

Salt Lake City - Utah Chiropractors Association has sued Blue Shield and state insurance commissioner for $2.2 million, charging discrimition because Blue plan won't pay spine punchers nor will commisoner require it to do so. Cultists say that Blue plan is a medil conspiracy in restraint of trade. Plan says it belongs to memrs of Utah State Medical Association. Chiropractors also asked urt to bar Blue Shield from doing further business in Utah.

V Researchers resee No NHI

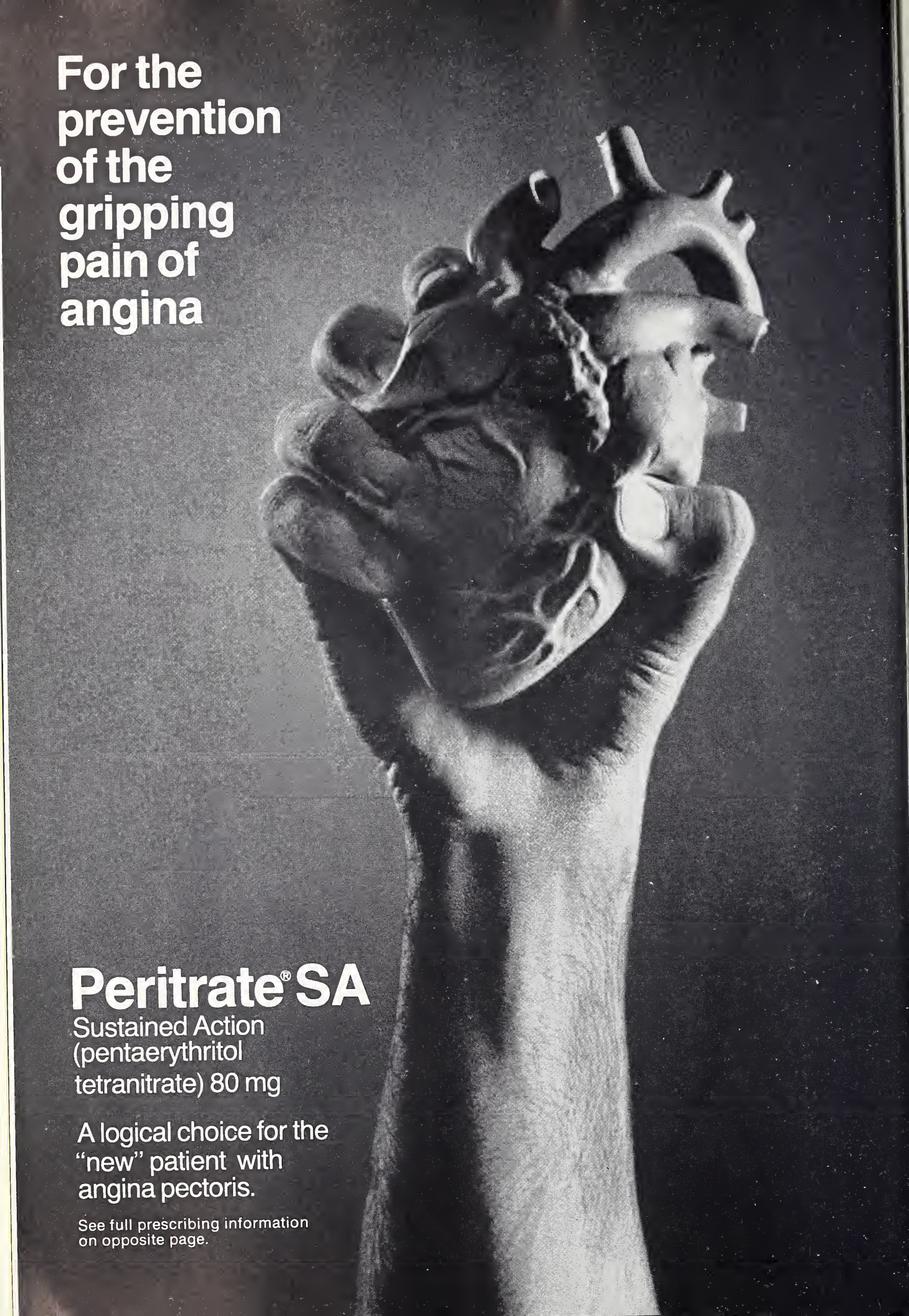
Washington - Do the HEW boys in the back room know something the Secretary doesn't? Maybe, according to "HEW Research and Statistics," a holarly though obscure publication with small circulation. Rent issue says that through 1980 "the current public medical care ograms will continue with no major changes in scope and type of nefits or in persons served." This is first and only pessimistic te from HEW on probability of national health insurance.

ability Coverage Up in Alabama

Montgomery - Professional liability insurance picture grows darker for Alabama physicians with companies having filed for 50 per cent premium te increase. With costs of a 100/300 policy hovering around the ,500 level for Class V surgery, present filing is sixth since 67. For those who do no surgery in Alabama, premiums have risen 5 per cent and for surgeons, 503 per cent. By contrast, Mississippi has fourth lowest premium rate in United States.

solete Rx Items e on FDA List

Washington - The Pharmaceutical Manufacturers Association says that two-thirds of the Rx products recently rated "ineffective" by FDA are f the market. The no-goodnik list was compiled after studies by e National Academy of Science and carried some items which had not en marketed for 20 years. Also included were non-Rx items such as othpaste and mouthwashes. Heavily hit were combination ingredient items which had been popular with practicing profession.


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PE-GP-11

Mental Health Training Program Announced

A "hire now—train later" career program in the undermanned mental health field has been announced by HEW's National Institute of Mental Health, Health Services and Mental Health Administration.

Launched with more than $2.5 million in Federal aid, the program will provide training for some 1,150 workers in 13 public agencies across the country.

"The policy of hire now, train later will help bring local, untrained people into programs where serious shortages now exist," said Dr. Bertram S. Brown, NIMH Director.

"The traditional practice of hiring only people who have had training has affected two vital segments of our economy, agencies which need help but cannot find it and people who need employment but are not trained for it."

In addition, the program will allow for upgrading and increased mobility for agency employees through further training and education.

It will serve as a national model to demonstrate how entry level personnel can be recruited from the community and then trained while actually on the job. It will also demonstrate how existing agency personnel can be upgraded or given greater mobility within their agencies.

The New Mental Health Careers Program, through 13 contracts with state, county, and local governmental agencies, will provide training for 780 entry level personnel and 469 upgraded personnel. Manpower training, while the basis for funding, is not the major emphasis of the program. The main goal is to stimulate institutional change in the use of staff for the delivery of services.

The program is also designed to encourage agencies to develop a permanent policy of hiring and training persons who do not have the traditional qualifications for entry level positions.

Another aim is the complete restructuring of the agencies' personnel systems to provide career "lattices" to all personnel. This would make possible, through training and education, career advancement from entry level to full professional status consistent with the ability and motivation of the individual employee. The "lattice" concept implies mobility from one job ladder to another within an agency as well as movement from one agency to another with full recognition for training and experience.

Alcohol and Drug Center Fills Positions

A nationally recognized authority on alcohol and drug abuse problems and a veteran hospital administrator have been appointed to key positions in a new Alcohol and Drug Treatment Center in Memphis.

Dr. David Knott will serve in a consultant capacity as medical director of the center which will be opened in May by Memphis-based Tranquilaire Mental Health Services, Inc. The new facility is located on a site adjoining the firm's Mental Health Center at the intersection on Highway 64 and Brunswick Road, northeast of Memphis.

Named as administrator of the Alcohol and Drug Treatment Center is Bill M. Edwards. Mr. Edwards was formerly administrator of the Tennessee Psychiatric Hospital, Memphis, and served 23 years in the United States Navy before retiring with the rank of Lieutenant Commander.

Dr. Knott said the treatment program at the center will be patterned after the successful program that now exists at the Alcohol and Drug Dependence Clinic at the Tennessee Psychiatric Hospital and Institute. "In terms of available bed space and the offering of quality health service," Dr. Knott said, "the Tranquilaire Center represents an important extension of existing rehabilitation programs in the Mid-South area."

Dr. Knott retains his present position as Director of the Alcohol and Drug Dependence Clinic, Tennessee Psychiatric Hospital and Institute, Memphis. He is a member of the Board of Directors of the National Council on Alcoholism and chairman of the research committee of the American Medical Society committee on alcoholism.

Mr. Edwards is listed in Who's Who in America, Royal Bluebook of England and the British Empire and Register of Prominent Americans. He holds the Presidential Unit Citation and a number of other military awards and honors.

Mr. Edwards is a graduate of the School of Hospital Administration, Washington, D. C. and holds a Bachelor of Law degree from LaSalle University, Chicago.

The appointments were announced by Dr. Robert L. Parrish, Tranquilaire's chairman of the board.

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Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
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Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
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March 1971, Vol. XII, No. 3

ORIGINAL PAPERS

Hereditary Hemolytic Disease

FRANCIS S. MORRISON, M.D.
Jackson, Mississippi

Hemolytic disease is considered as being either hereditary or acquired. Acquired diseases usually occur through extrinsic factors and hereditary conditions are the result of intrinsic defects in the red cell. The author focuses on the intrinsic defects of the red cell which are genetically derived. He discusses primary membrane defects, hemoglobin abnormalities and defects in the red cell's metabolic capacity.

HEMOLYTIC DISEASE IS conveniently considered as being either hereditary or acquired. This arbitrary division is particularly useful because it relates to pathogenic mechanisms in a broad sense. Acquired processes usually are mediated through extrinsic factors while the hereditary conditions are the result of intrinsic defects in the red cell.

The appellation hemolytic disease, describing conditions characterized by shortening of the red cell survival in the circulation is more precise than hemolytic anemia. If the marrow can increase the output of red cells by a factor of 10, then clearly the survival time in the circulation can be reduced by the same factor without any decrease in total red cell mass. Therefore unless the hemolytic process is abrupt in onset and or extremely severe, anemia may not be conspicuous or even present at all, despite demonstration of obvious compromise in the cell's ability to cope with its environment.

We are concerned herein with intrinsic defects of the red cell which are genetically derived and which handicap the red cell in its ability to live in the circulation for the normally allotted 120 days.

Viewed functionally, the red cell is merely a bag composed of a limiting membrane filled with a solution of an oxygen carrying protein, hemoglobin, and other proteins which permit metabolic activity. These elements are closely interdependent. For example, the metabolic activity is primarily directed toward maintaining the membrane as well as the hemoglobin itself in an optimal functional state. Recently, a relationship between hemoglobin and membrane function has also been recognized.[8, 12] The molecular basis, however, for known primary membrane disorders and the precise means by which known metabolic defects or hemoglobin disorders affect membrane function have not been uncovered. Defects in each of these

Presented before the Section on Medicine, 102nd Annual Session, May 13, 1970, at Biloxi.
From the Division of Hematology, Department of Medicine, University of Mississippi School of Medicine, Jackson, Miss.

three elements are known and will be discussed.

A primary membrane defect is postulated, with considerable experimental support, in Hereditary Spherocytosis. (H.S.).[9] Although the biochemical lesion is not known, this condition is definitely not due to defective energy metabolism. In fact these cells are capable of markedly increased work to maintain their integrity if sufficient substrate is supplied. There is, in H.S., loss of membrane lipid and sodium leak resulting in the characteristic morphologic change. With the decrease in substrate availability and lower pH which exists in the spleen, the cell is unable to exert this additional effort and cell death occurs. One can expect splenectomy to cure the patient without altering the basic defect. In fact, the most abnormal of the cells which could not survive passage through the spleen now circulate freely. The result is an exaggeration of the morphologic picture after the patient has been splenectomized. The important difference, however, is reflected in the increase in red cell mass and reduction of the reticulocyte count to normal.

VARIATION IN SEVERITY

This autosomal dominant condition has wide variation in severity and frequently exists as compensated hemolytic disease without anemia. As in all chronic hemolytic states, however, complications constitute a risk which, if possible, should be avoided, as in the case with H.S.

The two major complications to be expected are gallbladder disease and "aplastic crises." The gallbladder problems simply relate to the markedly increased catabolism of hemoglobin with the attendant risk of bilirubin stones. Splenectomy in a stable young patient is certainly attended by very little risk indeed when compared to emergency cholecystectomy.

The so-called "aplastic crises" are now generally considered a normal response of the marrow to infection. A transient interruption in marrow production of red cells while cells circulate for four months is hardly noticeable. However, if the red cell survival time is severely shortened, a transient interruption in production can be catastrophic. It is the abrupt situation associated with reticulocytopenia which has been referred to as an "aplastic crisis" and obtains in any severe hemolytic disease.

Hereditary elliptocytosis is a morphologically separable condition which is thought also to be due to a primary membrane defect. The response to splenectomy, in the severe form of the disease, has been as gratifying as is the case with H.S.

Defects in the major protein confined within the red cell membrane, hemoglobin, constitute another group of hereditary hemolytic diseases. New abnormalities are being described constantly despite the fact that only those amino acid substitutions in the globin chain which result in a change in net electrical charge are detectable by electrophoresis. Fortunately, most variants are not associated with serious hemolysis. Hemoglobins S, C and E in various genetic combinations may result in significant disease.[3]

UNSTABLE HEMOGLOBINS

The more recently described group of "unstable hemoglobins" are of particular interest. These are quite different from each other but share instability in solution as an unifying property which results in a very well-defined syndrome. There is hemolytic anemia beginning in infancy, usually splenomegaly, and, by definition, inclusion bodies within the red cell.[1]

There are at least four ways in which the hemoglobin molecule can lose its stability and precipitate within the cell. Unopposed oxidative reactions will be discussed further under enzymatic defects. Substitutions in the globin chain which affect either the site of heme binding or the overall globin conformation will also effect instability. The fourth cause is the presence of excess alpha or beta chains due to decreased production of its opposing chain as is found in the thalassemias. For example, in beta thalassemia there are excessive alpha chains which are not bound and will precipitate. The exact means by which these inclusions result in hemolysis is not resolved but brisk hemolysis may occur. The effect of splenectomy is variable but these patients should be cautioned about the use of drugs having known oxidant effects or other oxidizing stresses such as hyperbaric oxygen.

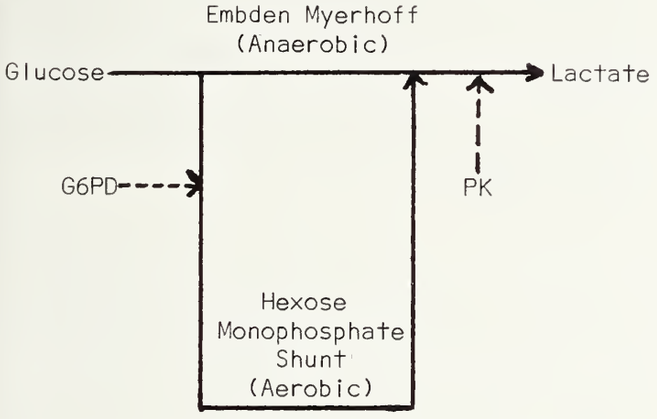
OXYGEN DISSOCIATION

Interest in hemoglobin abnormalities has been stimulated recently by the rediscovery that oxygen dissociation relates intimately to the shape of the hemoglobin molecule. Beyond the obvious inability of precipitated hemoglobin to bind oxygen for delivery, substitutions near the heme group can cause iron to remain in its oxidized nonfunctional state (Methemoglobin).[7]

Other abnormal hemoglobins may hold on too tightly to oxygen (Chesapeake) and thus cause tissue anoxia in the presence of normal oxygen saturation of the blood.[2] Erythrocytosis results. Hemoglobin Seattle has a decreased affinity for oxygen and does so well with oxygen delivery that the marrow is depressed.[14] Another hemo-

globin (Kansas), however, releases oxygen so easily that the red cell cannot even emerge from the lung with enough oxygen to avoid cyanosis at rest.[13] These last three types of hemoglobin, while doing much to stimulate renewed interest in the hemoglobinopathies, are not associated with hemolysis.

TABLE 1



Defects in the red cell's metabolic capability comprise the third group of hereditary hemolytic diseases. About 15 years ago a specific enzymatic defect in red cell metabolism was identified and established as a cause for previously unexplained hereditary nonspherocytic hemolytic anemia.[6] Many additional enzymatic defects have been discovered since that time but rather than discuss all of them it is more convenient to consider them as belonging to one of two groups based on whether aerobic or anaerobic glycolysis is impaired.

The normal red cell has the complement of enzymes required for glucose to negotiate both the Embden Myerhoff pathway of anaerobic glycolysis or the hexose monophosphate shunt (HMP) of aerobic glycolysis. A schematic diagram of these metabolic pathways is shown in Table 1 with the location of the two types of defects to be described.

However, the red cell is peculiar among cells in that it has no ribosomes so that no additional enzymes can be made after the initial supply has become depleted. It has enough to last normally about 120 days, but if the cell is deficient in the beginning, it will die sooner. There are many energy needs fulfilled by these glycolytic pathways. For example, there are constant oxidative challenges in a cell carrying a high concentration of oxygen in the environment of the circulation. To avoid self immolation, constant reductions must be made and this requires energy.

Heme is readily oxidized to Methemoglobin as we have already indicated and must be reduced to its functional state. Hemoglobin and membrane SH groups require GSH and this substance will be oxidized in the process only to require reduction. Energy is required to maintain the high potassium, low sodium concentration within the cell. Without adequate energy the red cell becomes sodium logged and spherical and is destined to be trapped in the inner recesses of the spleen.

The first enzymatic defect described was located in the HMP shunt. This pathway is not primarily concerned with energy production but rather with coupled reactions effecting many of the reductions mentioned above. The activity of this pathway must be capable of withstanding wide fluctuations in challenge to the state of balance.

The presence of a defect in the HMP was first appreciated in patients who suffered severe hemolysis when treated with primaquine or other antimalarial drugs. It is now clear that many other drugs as well as other insults such as infections can precipitate these crises in susceptible individuals.[5]

In addition to the drugs listed in Table 2, a whiff of naphthalene (moth crystals) may induce severe hemolysis. Many bacterial and viral infections as well as diabetic keto acidosis even without treatment commonly cause hemolytic episodes.

TABLE 2

A PARTIAL LIST OF INCRIMINATED DRUGS INCLUDES

Sulfonamides	Isoniazid	Phenacetin
Aspirin	Dilantin	Vit K
Choloramphenicol	Sulfones	Quinidine
Nitrofurantoins	Streptomycin	PAS
Primaquine	Acetanilid	

These agents all tend to cause oxidation within the red cell. Normally the HMP shunt would be activated and maintain the status quo. However, if the cell is deficient in any required enzyme in this cycle, the response is not sufficient. The result is methemoglobin formation, Heinz body formation (precipitated hemoglobin), loss of glutathione, membrane damage and rapid severe hemolysis.

There are many other defects which have subsequently been discovered in this pathway but the prototype is the first one described, G6PD deficiency. Not only is this defect better studied but it has greatest clinical significance because of the number of people who carry the gene.

Three phenotypes are apparent:

1) The commonest type occurs in 10 to 18 per cent of American Negroes as well as many people of Mediterranean origin. Because these af-

fected individuals have approximately 15 per cent of the normal amount of G6PD in their red cells they can do quite well until challenged by an offending agent or infection. It is of further interest that because young cells have more enzymes than old cells, if the patient survives a severe hemolytic episode the hemoglobin level will return to normal despite continuation of the drug. This is due to the attendant reticulocytosis and the resultant population of young cells replete with adequate enzymes. It is only after cessation of therapy for a period which allows the cells to age that rechallenge will precipitate a similar chain of events. This fact also explains why it is useless to assay for the deficient enzyme during or shortly after the hemolytic episode. The defect is inherited as a sex linked trait with intermediate penetrance so it is more common in the male.

2) Another form of the defect is quite similar except that there is an additional factor present which results in a sensitivity to Fava beans. Exposure to even the pollen of the Fava bean plant can induce severe hemolysis. The condition has long been known as Favism and occurs in Mediterranians. It is otherwise similar to the common form of G6PD deficiency described above.

3) A third variant of the defect occurs primarily in Caucasians and is characterized by virtual absence of the enzyme even in the very young cells. The result is chronic hemolytic disease due to normal oxidizing stresses even without overt challenge by any agent. Exposure to an oxidizing agent causes severe hemolytic anemia.

TABLE 3

		Hemolysis	
Medium	NORMAL CELLS	H.S.	P.K.
Plasma	4%	20%	40%
Plasma and Glucose	2%	2%	40%

Anaerobic glycolysis normally accounts for 90 per cent of the energy production of the red cell. Energy is utilized in the form of high energy phosphate bonds in the process but the net result is the production of two molecules of ATP for each molecule of glucose metabolized. As stated previously, the mechanism whereby a defect in this pathway and hence a defect in the economical production of ATP, effects a membrane abnormality with resultant hemolysis is not precisely understood.

The prototype of these defects is deficiency in pyruvate kinase (PK).[11, 15] The condition is inherited as an autosomal recessive trait. Affected individuals cannot generate one of the ATP molecules in the anaerobic path and therefore lack the energy capability of normal cells. A simple way to consider the mechanism of hemolysis is to merely look upon this deficient energy as a decreased ability to pump sodium out of the cell. A consideration of the behavior of these cells under the conditions of the autohemolysis test of Dacie contrasts PK deficiency with Hereditary Spherocytosis.[4]

Red cells are incubated at 37 degrees for 48 hours in plasma with and without additional glucose. See Table 3.

PER CENT HEMOLYSIS

Per cent hemolysis is determined by measuring supernatant hemoglobin. Normally there is less than 4 per cent hemolysis and this is further reduced in the presence of additional glucose. In HS there is severe hemolysis in plasma but added glucose obviates this completely. The HS cells are capable of increased energy production with more hemolysis in the plasma and additional glucose has no salutary effect whatsoever. Clearly, additional substrate is of no value if the cell cannot utilize it.

There have been seven enzymatic defects detected thus far in the anaerobic pathway. By and large they result in a similar problem of congenital nonspherocytic hemolytic anemia. They are variable in severity and inheritance. Differentiation within the melange is useful primarily for theoretical reasons.[10]

It should be mentioned that these defects are defined by assays which measure enzyme activity and/or substrate buildup behind the deficiency. Clearly the defect may result from either quantitative decrease in enzyme or a qualitative abnormality of the enzyme protein. In fact both types of defect have been hypothesized. Electrophoretic separation has revealed abnormal migration in at least one patient with a defect (Hexosephosphate Isomerase). While this may suggest structural aberration detrimental to function, many isoenzymes have been known to exist normally in various cellular environments so this problem is not yet resolved.

The major clinical significance of these disorders is their recognition and differentiation from conditions which may necessitate interdiction of certain drugs or may be curable by splenectomy. Furthermore, a logical approach to the diagnosis and treatment of anemia requires an understanding of the possible broad mechanisms of hemoly-

tic disease which may be operative in any given case.

Iron loading is a problem in chronic hemolytic disease so these patients should not receive iron nor should transfusion be used to maintain an arbitrarily chosen hematocrit level. Folic acid is marginally supplied in most of the diets and in patients with a rapidly proliferating marrow, a deficiency is exaggerated. Folic acid supplementation is frequently helpful. The value of splenectomy except in the defective membrane disorders is still unclear and the decision for or against must be tailored to the individual patient. ★★★

2500 North State Street (39216)

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SAD CASE, INDEED

Listed under "cause of death" on a death certificate filed in the Bureau of Vital Statistics in Tallahassee, Fla.:

"Don't know. Died without the aid of a physician."

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 20-24, 1971, Atlantic City, Clinical Convention, Nov. 28-Dec. 1, 1971, New Orleans. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

STATE AND LOCAL

Mississippi State Medical Association, 103rd Annual Session, May 3-6, 1971, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Mississippi Academy of General Practice, Annual Assembly, June 24-26, 1971; Biloxi. Miss Louise Lacey, Executive Secretary, P.O. Box 3112, Jackson 39207.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Robert P. Henderson, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Second Wednesday, April and First Wednesday, November, 2:00 p.m., Clarksdale. Glenn L. Wegener, 1967 Hospital Drive, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. James E. Booth, Eupora, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. M. Howell, 139 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. A. Robert Dill, 1001 Main Street, Columbus, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Robert Donald, Box 1351, Pascagoula, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie Street, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday, January, April, July, and October, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.

Cardiac Disease in the Newborn

DAVID G. WATSON, M.D., and
BERT E. BRADFORD, M.D.
Jackson, Mississippi

Most neonatal cardiac problems relate to congenital cardiovascular malformations and occur in 0.3 to 0.7 infants per 1,000 live births. With new and better methods of diagnosis, therapy and support, it is imperative that physicians detect these infants early and institute the indicated measures in order to reduce the high mortality. The authors discuss detection, physical examination, diagnostic tools and approach to management for the various cardiac diseases in the newborn.

NOT LONG AGO THERE was little beyond simple supportive management available to the neonate with symptomatic heart disease. Better means of support, better knowledge of heart disease in this challenging age group, better diagnostic methods, and better medical and surgical therapy are now available. Thus, there is now a greater obligation to detect such infants so as to promptly institute indicated basic supportive and therapeutic measures, and to seek specialized diagnostic and therapeutic care when required.[1, 2, 3]

Most neonatal cardiac problems relate to congenital cardiovascular malformation. The estimated incidence of congenital heart disease varies from 0.3 to 0.7 per 1,000 live births. More than half of these defects can be detected during the neonatal period. For those with severe defects, the chances of survival to age one year are still less than 50 per cent, but are improving, with a good chance for definitive correction of their cardiac defect at acceptable risk.

The incidence of congenital cardiac defects are only slightly higher (2 to 3 per cent) in the siblings or children of those known to have such a defect. However, there is a strong tendency for the new family member to have the same or a very similar malformation as his parent or sibling.

Maternal rubella, particularly during the first trimester, can produce patent ductus arteriosus, supravalvular pulmonary and aortic stenosis and other cardiac and non-cardiac disease. Other viral illnesses during early pregnancy have been suspected of causing congenital defects, but definite relationships with specific cardiac defects have not been established.

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The overall sex ratio for congenital heart disease is about equal, but patent ductus arteriosus is more common in girls, and transposition of the great arteries, and coarctation of the aorta are more common in boys. Less is known about racial incidence, but both transposition of the great arteries and coarctation of the aorta seem less common in Negroes than in Caucasians. Infants with congenital anomalies are 2.5 times as likely to be premature as are well formed infants. However, among sick newborns, the occurrence of congenital heart disease as a cause of the morbidity is much higher in the fullterm than in the premature group. The history regarding fetal distress, delivery and Apgar scoring, and the mother's pre- and post-partum course helps differentiate cardiac disease from pulmonary, infectious, and other disease.

Physical examination consists of six key findings:

(a) *Respirations*

The respiratory rate should not normally exceed 45 per minute in a fullterm or 60 per minute in a premature infant. Anoxia, primary pulmonary disease, and congestive heart failure can increase the rate, and with the latter two it may exceed 100 per minute. With heart disease the air entry should sound normal to auscultation, but with pulmonary disease there usually is generalized or localized reduction in air entry. There may be intercostal, subcostal, and sternal retractions, and grunting with both congestive failure and with respiratory distress. Unless anoxic brain damage has occurred, the respiratory activity in both cardiac and pulmonary disease is usually regular, whereas in central nervous system disease with pulmonary hypoventilation it tends to be irregular.

(b) *Color*

Cyanosis may be difficult to assess.[4] In the first few days cyanosis of the hands and feet may occur in the absence of heart or lung disease, and more generalized cyanosis on crying may also be seen, presumably due to transient right-to-left shunting through the patent foramen ovale or ductus arteriosus. Vasomotor instability is characteristic of infancy—the trunk and extremities become mottled after cooling or crying. However, persistent cyanosis in the neonate, especially if generalized, suggests significant disease. This occurs as commonly with intracranial and respiratory disease as with cardiac disease. Cyanosis due to respiratory disease is more likely to clear with crying or with oxygen administration than that due to the central right-to-left shunt of cardiac disease, but this is not completely reliable.

Some babies with heart failure have a grayish pallor. Jaundice develops more frequently in babies suffering anoxia than in those who do not.

TABLE I

EKG CRITERIA FOR VENTRICULAR HYPERTROPHY IN THE NEONATAL PERIOD

Right Ventricular Hypertrophy is suspected if:

	Age		
	0-24 HRS.	1-7 DAYS	> 7 DAYS
R in VI exceeds	20 mm.*	29 mm.	20 mm.
S in V6 exceeds	14 mm.	14 mm.	10 mm.
R/S in VI exceeds	6.5	6.5	6.5

Left Ventricular Hypertrophy is suspected if:

	Age	
	0-24 HRS.	> 24 HRS.
S in VI exceeds	28 mm.	19 mm.
R in V6 exceeds	16 mm.	16 mm.
R/S in VI is less than	0.8	0.8

* Voltage readings in mm. assume a full standardization of 10 mm./millivolt.

(c) *Pulses*

The brachial or axillary pulses should be felt in the newborn and compared to the femoral pulses. With a pathologically patent ductus arteriosus the pulses may be unusually strong; with hypoplasia of the left heart or any patient with severe congestive failure, all pulses may be weak; and with coarctation of the aorta the arm pulses may be normal and the leg pulses absent. Using an infant cuff, and a stethoscope with a pediatric head, the blood pressure can sometimes be obtained even in the neonate by auscultation. More special equipment, such as an oscillometer or Doppler blood pressure unit, may be necessary, however.

(d) *Heart Murmurs*

Murmurs are less helpful diagnostically in the newborn than in the older patient. Many with severe defects have no murmur. Some have none early but later develop one which may even become quite loud. This is especially true when the normally high pulmonary vascular resistance of the newborn minimizes a left-to-right shunt through a ventricular septal defect or patent ductus, only to decrease and allow a greater shunt later. On the other hand, a transient "ductus closing" murmur may be heard during the first day in infants with no heart disease, and is more frequent in those with respiratory distress. Also, innocent vibratory systolic murmurs may be heard in this age group and may transmit throughout the chest whereas in older children it is confined to the precordium. In all, about 60 per cent of normal newborns have a heart murmur. Thus, a murmur in the absence of cyanosis, cardiomegaly, heart failure or other signs of distress does not require early definitive diagnosis. Stenotic murmurs, such as that of Tetralogy of Fallot, may be heard very early and are helpful in diagnosis.

(e) *Signs of Heart Failure*

Tachypnea with dyspnea is nearly always present. Most babies in failure also have a liver enlarged so that its edge is felt 3 cm. or more below the costal margin in the mid-clavicular line. Less frequently there may be edema, pulmonary rales, or a gallop rhythm. However, many normal newborns have periorbital puffiness, and at a few weeks of age many premature infants have shiny

edema of the lower extremities. Pulmonary disease may cause rales, and there are many possible causes of liver enlargement. Thus, while it is important to suspect heart failure when any of the foregoing signs are present, the diagnosis is doubtful unless more than one is found, and there is confirmation such as heart enlargement on chest x-ray, elevation of the venous pressure above 10 cm. of blood or saline (if the umbilical vein is catheterized and the external tubing is held vertical, the height of the column of blood is a good indication of this), or other findings in keeping with a severe cardiac defect.

(f) *Extracardiac Findings*

About 40 per cent of infants with mongolism and a higher percentage of those with other trisomies have a significant heart defect. Thus, careful cardiac examination supplemented by an electrocardiogram and chest x-ray are advisable. Newborns with Turner's Syndrome should be suspected of having coarctation of the aorta. Those noted to have significant anomalies of the central nervous, skeletal, or genitourinary systems should be suspected of having a heart defect also.

CHEST X-RAY

A properly exposed, P-A chest x-ray, without patient rotation, and hopefully made on inspiration is very useful. The cardio-thoracic ratio (transverse diameter of the heart divided by the internal diameter of the chest at the level of the diaphragm) provides a useful evaluation of heart size. In most normal newborn infants this ratio will not exceed 55 per cent. One can be misled by a large thymus. It is well also to remember that in the respiratory distress syndrome and other pulmonary disease, the cardiac silhouette may be obscure and/or appear large.

The pulmonary vascular markings are rather difficult to evaluate. Because the relatively high pulmonary vascular resistance in the newborn restricts pulmonary blood flow, the vascularity normally appears rather sparse during the first few days, and it is easy to misinterpret this as hypovascularity. We should also note that the pulmonary venous congestion seen in heart failure (particularly as related to hypoplasia of the left heart or anomalies of pulmonary venous return), is very similar to the ground-glass appearance of the lungs in the respiratory distress syndrome. The great vessels are usually poorly seen early. The lung parenchyma should be evaluated for evidence of disease, the position of the stomach and liver checked, and any apparent skeletal anomalies noted.

The mean frontal QRS axis in the normal newborn is usually between +30 and +120 degrees. It is common knowledge that the neonate shows relatively more right ventricular activity than the older child or adult. Table I indicates criteria[5] by which ventricular hypertrophy for this age can be determined. Tall peaked P waves (2.5 or more mm. tall in Leads I or II at normal standardization) indicate right atrial hypertrophy. Left atrial hypertrophy with broad notched P waves is unusual at this age. Arrhythmias may be noted and will be discussed later. ST-T abnormalities occur especially with myocardial ischemia, as in babies with aortic atresia. Any medical practitioner using the foregoing information to evaluate an infant's electrocardiogram himself can obtain more reliable help than he can from reading an interpretation based on adult standards.

LABORATORY AIDS

Many community hospitals now have equipment to determine blood pH, PO2, and pCO2. In the critically ill newborn the risk of aseptically inserting a plastic 3.5 Fr. feeding tube with a radio-opaque marker in the umbilical artery for sampling can be justified. A healthy newborn achieves normal adult values by 24 hours of age. An arterial pO2 less than 75 mm. Hg (or arterial oxygen saturation below 95 per cent) after this is abnormal. Administration of 100 per cent oxygen may improve the arterial blood oxygenation in an infant with a right-to-left shunt but should not return it to normal. A better response, perhaps to normal or above, is characteristic of infants with hypoventilation related to pulmonary or intracranial disease. Arterial or even venous blood pH is a useful guide to the degree of acidosis which may occur in cardiac or other severe neonatal illness and helps guide therapy.

DIAGNOSTIC FINDINGS

Because the hemoglobin tends normally to be high in neonates, polycythemia is not a helpful diagnostic finding. However, anemia may precipitate heart failure in an infant who might remain compensated in the presence of a normal hemoglobin. Hypoglycemia may complicate congenital heart disease in the newborn, especially transposition of the great arteries, or hypoplasia of the left heart. Severe hypoglycemia, as in the infant of a diabetic mother, may produce cyanosis and cardiomegaly which responds to glucose infusion. Thus, testing the blood with Dextrostix or blood glucose determination is useful.

We wish to stress that in order to salvage newborns with severe cardiac disease, one must: (1) *Suspect Cardiac Disease* and try to differentiate it from pulmonary and other disease. As discussed, clues may include family and prenatal his-

tory, tachypnea, dyspnea, cyanosis, abnormal pulses, liver enlargement, edema, rales and cardiac enlargement. (2) *Assess the Effect on the Infant*. A newborn with a heart defect may have a murmur, even with cyanosis, x-ray and EKG changes and yet be in no distress. Specific diagnosis will then only be urgent if the findings are compatible with a lesion likely to produce early deterioration. Those with distress usually suffer from either anoxia or heart failure. These two conditions and their management will now be discussed.

The problem of anoxia is frequent in infants: (a) with greatly reduced pulmonary blood flow (as in severe Tetralogy of Fallot, tricuspid or pulmonary atresia) or (b) with inadequate return of the pulmonary blood flow to the systemic circulation (as in transposition of the great arteries without a large ventricular septal defect or patent ductus arteriosus). Anoxic infants in both the above groups may have no heart murmur, and their chest x-ray may look nearly normal, but all will have abnormal EKG's and blood gas studies. Such babies should be quite cyanotic, but this is sometimes overlooked in dark skinned infants. Even infants with a fair complexion may have a more greyish than bluish color. Unless there is secondary anoxic brain insult, they have regular tachypnea with good air entry, and little dyspnea. Usually they are listless, feed poorly, may regurgitate and may become hypothermic.

TREATMENT FOR ANOXIA

Treatment includes maintaining normal body temperature in an incubator because hypothermia aggravates the problems of acidosis and increases the tendency to arrhythmia. Oxygen administration including the use of a face funnel or mask may be safely used up to the level where clinical improvement is apparent. If the suck is poor, the infant should be fed by stomach tube or intravenously. However, gavage feeding carries the risk of aspiration pneumonitis.

If the infant is restless or anoxia is episodic, morphine (0.2 mg/Kg.) may be tried, especially in those whose chest x-rays indicate reduced lung vascularity. The severely anoxic infant is nearly always acidotic and can be given intravenous sodium bicarbonate, 2-4 meq/Kg. in a slow intravenous push. Intravenous sodium bicarbonate may need to be continued, in the manner outlined in a previous article in this series[6] for the management of clinical hyaline membrane disease; hypoglycemia should be corrected; and adequate carbohydrate intake maintained.

If available, monitoring equipment to detect bradycardia or apnea and sound an alarm may be used. Severe anoxia due to inadequate pulmonary blood flow is ominous because a shunt operation (aortic-pulmonary artery or subclavian artery-pulmonary artery anastomosis) may fail or prove fatal in so small a child. The outlook for those with transposition of the great arteries and inadequate circulatory mixing has been brightened by the development of balloon septostomy by Rashkind.[7] This enables survival for later palliative or definitive surgery, and makes early referral of such infants for possible cardiac catheterization sometimes quite rewarding.

HEART FAILURE

Heart failure is frequently found early in infants with hypoplasia of the left heart and transposition of the great arteries with associated defects; and somewhat later in those with large ventricular septal defect or patent ductus arteriosus, truncus arteriosus, or total anomalous pulmonary venous return. The signs of heart failure have already been discussed. These babies may be restless or listless and may feed poorly, regurgitate and/or become hypothermic. The presence or absence of cyanosis depends mostly on the underlying lesion. The chest x-ray usually shows cardiac enlargement, often with increased pulmonary vascularity due to prominent arterial markings and/or pulmonary venous congestion.

Supportive temperature maintenance, oxygenation, assisted feeding, and correction of hypoglycemia and acidosis if present, as outlined for the management of anoxia, are in order. It may help to tilt the supporting tray in the incubator to elevate the head and assist respiration. Those infants in failure should be digitalized with Lanoxin (digoxin) using a total digitalizing dose of 0.05 mg/Kg. Two-thirds of this may be given as one dose intramuscularly or slowly intravenously, and the remainder within four to six hours. Even in the absence of edema, the baby in obvious failure should be given a rapid acting diuretic and in the authors' experience, Edecrin (ethacrynic acid), 1-2 mg/Kg. intravenously has given a good response. Antibiotics may certainly be used if there is any suggestion of infection.

SURGICAL TREATMENT

For a number of these infants with early congestive heart failure, palliative or corrective surgery is available, and the effort to treat them promptly and adequately is worthwhile. If the failure cannot be well controlled medically, then early cardiac catheterization may well be considered.

TABLE II

Diagnoses	*Cyanosis*	*Heart Failure*	*Murmur*	*Pulses*	*Heart Size*	*Pulmonary Vascularity*	*EKG*
Transposition	+	±	Varies	Usually N	N or +	Often congested	RAD, RAH, RVH
Coarctation	±	+	±	Femorals 0	+	Often congested	RVH
Aortic atresia	+	+	Slight or 0	Weak	+	Often congested	RVH, abn. ST
Tetralogy	+	0	Systolic	N	N	Reduced	RAD, RVH
Tricuspid atresia	+	0	Systolic	N	N	Reduced	LAD, RAH, LVH
VSD	0	±	Systolic	N	+	Increased	RVH or CVH
PDA	0	±	Systolic or continuous	May be strong	+	Increased	RVH or CVH
Truncus	±	+	Systolic	N	Usually +	Increased	RVH, LVH, or both
Endocardial cushion defect	±	±	Usually systolic	N	+	Increased	LAD, RVH or CVH
TAPVR	±	+	Systolic	N	N or +	Congested	RAD, RAH, RVH
Myocarditis	0	+	0	N	+	N or congested	Low voltage, abn T.

Legend VSD = Ventricular Septal Defect; PDA = Patent Ductus Arteriosus; TAPVR = Total Anomalous Pulmonary Venous Return; RAD = Right axis deviation; LAD = Left axis deviation; RVH = Right ventricular hypertrophy; RAH = Right atrial hypertrophy; LVH = left ventricular hypertrophy; CVH = combined ventricular hypertropy.

Although we are stressing general detection of heart disease and management of anoxia and heart failure, it may be helpful to briefly describe the typical features of the more common entities, and indicate the specific treatment available. (See also Table II.)

Accounting for about 50 per cent of CHD, transposition of the great arteries is the most common cause of cyanosis in the neonate. The pathology consists of inversion of the great vessels such that the aorta originates from the anterior (right) ventricle and the pulmonary artery from the posterior (left) ventricle. Clinically these patients present with cyanosis as the cardinal finding, usually developing in the first week. Congestive heart failure and death usually soon follow unless the infant's condition is diagnosed and adequately managed early.

Physical findings relate to the associated defects (ventricular septal defect and/or patent ductus) and to congestive heart failure if present. Murmurs when present are usually those found with ventricular septal defect, or pulmonary stenosis. Radiographically, the classical finding is egg-shaped cardiomegaly with increased pulmonary vasculature. However, the chest x-ray may often not be typical during the first few days. The EKG usually demonstrates right axis deviation, right atrial hypertrophy, right ventricular and occasionally combined ventricular hypertrophy.

Three procedures are available after medical management has begun. First, a balloon septostomy (Rashkind) wherein an atrial septal defect is created by a balloon catheter. If this is inadequate, a Blalock-Hanlon procedure creating a surgical atrial septal defect can be attempted with increased mortality (20 per cent). If indicated, pulmonary artery banding can be done at this time as well. If adequate mixing of the circulation is obtained, and pulmonary hypertension is avoided, a corrective operation (Mustard procedure) is available in later childhood.

Hypoplastic left heart consists of coarctation of the aorta or aortic atresia. Infants presenting with coarctation of the aorta differ from older children and adults in that the whole aortic arch is small, the left heart chambers and valves may be underdeveloped, and associated defects (especially patent ductus arteriosus and ventricular septal defect) are frequent. As a result this is the most common cause of heart failure in the neonatal period and the prognosis is poor.

The distinctive finding is absent or weak femoral pulses, as compared to normal pulses in the arm. Blood pressure determinations will confirm this disparity. There may be no murmur, a slight

parasternal murmur, or the murmur of a ventricular septal defect. The chest x-ray is not specific, and the EKG shows right ventricular hypertrophy (either because of pulmonary hypertension or associated underdevelopment of the left heart).

Vigorous medical management of the heart failure is tried first. If this fails, surgery can be considered, but carries very high risk. The survivors can be corrected in later childhood.

In aortic atresia, the left ventricular outflow is completely obstructed and all cardiac output is through the pulmonary artery, which supplies the aorta through the patent ductus. This is said to be the most common cause of heart failure in the first week of life, and few patients survive more than a week. Cyanosis, heart failure and even shock develop rapidly and all the pulses are usually weak. The chest x-ray is not specific and the EKG shows right ventricular hypertrophy and ST abnormalities. There is no established effective treatment.

Tetralogy of Fallot comprises about 10 per cent of congenital heart defects and usually presents in the newborn with a murmur and/or cyanosis. The anomaly consists of a large subaortic ventricular septal defect and pulmonary stenosis. In the newborn the degree of pulmonary blood flow is the critical factor for survival. An ejection murmur along the left sternal border, due to infundibular stenosis, is usually heard. Lack of a murmur and deep cyanosis carry a grave prognosis because they indicate very poor flow through the pulmonary outflow to the lungs. The second heart sound is loud and single in severe stenosis or atresia but may be split in milder stenosis. Congestive heart failure is rare.

RADIOGRAPHIC FINDINGS

Radiographically the heart size is normal or only modestly enlarged in most, and the pulmonary vasculature diminished; 25 per cent have a right aortic arch. The electrocardiogram of the classic Tetralogy of Fallot shows right axis deviation and moderate right ventricular hypertrophy, but the P waves are usually normal.

Treatment of most of the patients is medical. The unusual infant with severe cyanosis from birth and showing no murmur needs a systemic-pulmonary artery shunt such as a Pott's aortic-pulmonary anastomosis. Prognosis for this particular group is indeed poor, but for those who survive infancy, total correction will be available in later childhood and achieves good results.

Tricuspid atresia is an uncommon defect of the tricuspid valve and is usually associated with pulmonary stenosis or atresia and the pulmonary blood flow is decreased. Signs and symptoms mimic Tetralogy of Fallot.

Radiographically the heart size is usually normal with decreased pulmonary vasculature. The EKG helps differentiate this defect from Tetralogy of Fallot as it demonstrates left axis deviation, left ventricular hypertrophy, and right atrial hypertrophy. Treatment has been disappointing. Surgical procedures (superior vena cava-pulmonary artery and aortic pulmonary anastomosis) are available; however, mortality is high in the first year.

Ventricular septal defect (VSD) is the most common lesion accounting for about 25 per cent of CHD. We will only discuss those with isolated defects. The physiologic effect of an isolated VSD correlates directly with its size. Also, a VSD low in the septum is more likely to close spontaneously.

VSD CLINICAL FINDINGS

The clinical findings of a VSD in the neonate change with age. The normally high pulmonary vascular resistance that exists for the first few days gradually decreases over several weeks. Accordingly, the right ventricular pressure falls allowing increased left to right shunting and thus a louder murmur, which may become pansystolic and have a thrill. The majority of patients with a large VSD who become symptomatic do so within the third to sixth week of life, and may develop signs of failure.

Radiographically the heart size is usually moderately enlarged with a significant VSD. The pulmonary vasculature increases as the pulmonary resistance falls. The EKG shows right axis deviation and right ventricular hypertrophy often followed later by combined ventricular hypertrophy.

Treatment consists of medical management for the majority of the patients. This failing, pulmonary banding can be accomplished as a temporary measure with ultimate closure of the VSD later in childhood if indicated.

Normally a ductus closes within the first 24 hours of life. Hypoxia from any cause tends to maintain the patency. Symptoms related to a patent ductus arteriosus (PDA) correlate with size of the ductus and the presence of associated defects. In general, the PDA is first detected by auscultation. The murmur is usually best heard along the upper sternal border and may not sound continuous. Other possible findings include a loud second heart sound and bounding pulses. With an unusually large PDA, heart failure can occur, but is not common.

The chest x-ray is similar to that seen with a

ventricular septal defect. The EKG in patients with large shunts with early congestive heart failure have either right ventricular or combined ventricular hypertrophy. Left ventricular hypertrophy develops later in the newborn period. Treatment is primarily medical in cases of congestive heart failure with ligation reserved for unresponsive patients. The majority without failure are watched carefully with ligation done later.

Truncus arteriosus is a malformation in which one vessel arises from the heart and the pulmonary arteries originate from this trunk. The incidence is 1 to 4 per cent of CHD in the newborn period. This entity should be suspected in any neonate who presents with cyanosis on crying, congestive heart failure, a medium or low pitched systolic murmur along the lower sternal border and a single second sound. If cyanosis is not apparent, the findings often suggest a large VSD.

Radiographically there is moderate cardiomegaly with markedly increased pulmonary vasculature. A right aortic arch is found in 50 per cent. The electrocardiogram reveals a normal QRS frontal plane axis and hypertrophy of one or both ventricles.

Treatment of the heart failure which is usually present sometimes provides improvement. Mortality is high with most patients dying in the first six months. A palliative procedure (pulmonary artery banding) is available but the prognosis is nevertheless poor.

ENDOCARDIAL CUSHION DEFECT

The complete endocardial cushion defect (atrioventricularis communis) consists of deformed and insufficient mitral and tricuspid valves along with defects low in the atrial septum and high in the ventricular septum. This is frequently associated with Down's Syndrome (mongolism). The anomaly has varying clinical presentations depending on the severity of the defects. Only the complete endocardial cushion defect causes cardiac failure in the neonate. Cyanosis is variable, as are murmurs. Characteristically, the EKG shows left axis deviation with combined or right ventricular hypertrophy. The heart is enlarged radiographically with increased pulmonary vascularity. Treatment consists of medical management of congestive heart failure. Surgical procedures, while occasionally successful, are generally unrewarding and the prognosis is poor.

In total anomalous pulmonary venous drainage, all the pulmonary veins fail to empty into the left atrium and instead enter into a systemic venous pool such as the left superior vena cava, right atrium, coronary sinus, or portal vein. Enough blood must pass from right to left atrium to provide blood for the systemic circulation. Frequently, the pulmonary venous pathway is partly obstructed, and this contributes to the pulmonary hypertension which persists in most of these babies.

Clinically, these neonates have generalized cyanosis (but this may be faint, and only present on crying), usually with a pulmonary ejection murmur, enlarged liver, tachypnea, and congestive heart failure. Radiographically the heart size is normal or slightly enlarged with pulmonary plethora. The EKG reveals right axis deviation, marked right ventricular hypertrophy, and right atrial hypertrophy.

Survival depends upon adequacy of pulmonary blood flow, and lack of significant anatomic obstruction to the pulmonary venous return. Medical management of the heart failure often fails. Balloon atrial septostomy may be useful to enable better shunting of blood from right to left atrium. Surgical correction in infancy carries a very high risk, with few reported survivors, whereas those who live past infancy have a much better surgical outlook.

NEONATAL MYOCARDITIS

Neonatal myocarditis may be acquired by the transplacental passage of a viral agent, most commonly Coxsackie B or rubella. Clinical manifestations develop in 3 to 10 days and consist of fever, tachycardia disproportionate to the degree of fever, tachypnea, refusal to feed, and often arrhythmias, gallop rhythm, and hepatomegaly.

Radiographically the heart is of normal size early, followed by enlargement. The EKG usually shows low QRS voltage with flattening or inversion of the T waves, with or without depression of the ST segments. Treatment should consist of judicious use of anticongestive measures such as digitalis, oxygen, and diuretics. Digitalis should be continued once begun until the cardio-thoracic ratio approaches 0.55, as abrupt withdrawal may result in recurrence of CHF.

CARDIAC ARRHYTHMIAS

We will discuss three cardiac arrhythmias:

(a) *Paroxysmal Atrial Tachycardia*

This uncommon disorder presents with a characteristic clinical picture. The heart rate is greater than 210 per minute—usually 240-260/minute. The infant becomes restless, pale grey, refuses to feed and may vomit. Cardiac failure usually follows if the disorder persists longer than 24 hours. The heart size may be normal, but enlarges early and may reach an enormous size. The EKG reveals tachycardia and no P waves.

Immediate therapy is indicated and consists initially of digoxin. One-half to two-thirds the total digitalizing dose is given IM and the remaining over six to eight hours. If the tachycardia persists longer than two to three hours, carotid massage may be effective. Usually this, as well as other methods of vagal stimulation, are ineffective in the neonate without digitalization first. Alternate drugs which have been reported effective are quinidine and prostigmin.

In the neonate with advanced congestive failure or with the tachycardia lasting longer than 24 hours, direct current countershock (with 10-20 watt-seconds of power) can be used. The prognosis is excellent though 20 per cent have recurrences. After the paroxysm has ceased, some have the EKG findings of the Wolff-Parkinson-White Syndrome. Digoxin should be maintained for about six months as a precautionary measure.

(b) *Complete Heart Block*

A congenital defect, this disorder results from disturbance of the bundle of His or both branches as a consequence of infective metabolic or vascular etiologies. About half have associated malformations of the heart. Infants may have no symptoms or show dyspnea, tachypnea, cyanosis and/or congestive heart failure. Heart rates between 30 to 45 are usually associated with symptoms while those greater than 50 are not. Clinical findings include variations in the intensity of the first heart sound, muffled heart sounds, and cardiomegaly. The EKG confirms the complete block.

Treatment of the symptomatic neonate is medical initially and consists of atropine I.M. (0.05 mgm or less) or isoproterenal I.V. (4 mgm in 1000 cc D5W as a constant drip with the rate of infusion depending upon the response).[8] Rarely an internal artificial pacemaker may be necessary later. Neonates without symptoms within 72 hours usually remain asymptomatic and in the absence of associated defects have a good prognosis. Symptomatic neonates with abnormal QRS complexes and an associated defect have a poor prognosis.

(c) *Ventricular Arrhythmias*

A rare occurrence in the neonate, arrhythmias such as frequent ventricular extrasystoles or even ventricular tachycardia are an ominous finding as they may lead to ventricular fibrillation and death. Treatment is medical and consists of lidocaine (xylocaine) in the dosage of 0.5 mg/lb by I.V. Quinidine sulfate 1-3 mg/Kg. I.M. or procaine amide (6 mg/Kg. I.M. Q 4-6 hrs. or 2 mg/Kg. I.V. diluted in D5W) may also be tried.

Allusion has already been made to the usefulness of cardiac catheterization to establish the diagnosis in congenital heart disease, and to perform balloon atrial septostomy when indicated. During catheterization, the infant can be kept warm with an Aqua pad, given oxygen, and his electrocardiogram and rectal temperature can be monitored. During the first week, catheterization can usually be performed via the umbilical vessels. Most of the likely diagnoses can be demonstrated by one or two appropriate angiocardiograms. Pressure and oxygen determinations are useful but not absolutely necessary. Blood gas and glucose determinations may guide the supportive measures. Balloon septostomy may be promptly done if indicated. The risk of cardiac catheterization in those neonates requiring this procedure is about 5 per cent (within the first 24 hours); this probably approximates the natural mortality.

SUMMARY

It is usually possible to suspect significant neonatal heart disease early and to differentiate it from pulmonary and other disease. The nature of the distress, usually anoxia or heart failure, can be assessed and supportive management started. Definitive diagnosis and management may require early cardiac catheterization. ★★★

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Seminar on Moral Aspects of Abortion

JOHN M. ALFORD, JR., M.D.
Greenwood, Mississippi

WHAT ARE YOU DOCTOR, when you're not a doctor?"

This is a question asked by Carlyle Marney at a seminar both clergymen and physicians attended. Are there questions, other than medical, that the physicians of this land should not side-step?

In many places, officially, the physicians recognize only the medical indications for abortion. Unofficially, many physicians act in such a way as to secure a wanted abortion.

More recently, the AMA has "clarified" the position of the doctor by stating that the matter should be decided by the patient in consultation with her doctor.

Where the law has been liberalized, some liberal physicians, who are qualified, have proceeded to abort individuals on a wholesale scale and in one account of this development, it is evolving as something the community is accepting.

In spite of these developments, we have decided to ask the harder questions once again and try to deal with the things that disturb your sensitivities to life.

At this meeting men disciplined in the ministry have been asked to discuss this problem with us. Medical knowledge alone is not sufficient, and disciplines of knowledge must continue to get help from one another. It is particularly relevant, amid the manifold voices changing social fabric at a dizzy pace, for influential men and associations to seek to restore equilibrium. ★★★

401 River Road (38930)

Chairman, Committee on Medicine and Religion, Mississippi State Medical Association.

Presented before the Board of Trustees, Mississippi State Medical Association, on December 9, 1970, at the Medical Alumni House, Jackson.



The guest speakers for the Seminar on Moral Aspects of Abortion chat informally with the MSMA Board of Trustees at the Medical Alumni House luncheon. The seminar was presented to the Board for information and discussion by Dr. John M. Alford of Greenwood, chairman of the MSMA Committee on Medicine and Religion.

A Clergyman's View

MSGR. JOSIAH G. CHATHAM
Jackson, Mississippi

In recent years, information concerning human reproduction has increased greatly. Drawing especially upon an article by Dr. André E. Hellegers of Johns Hopkins and Georgetown Medical Schools,[1] I will attempt to sketch the present state of medical knowledge, and then suggest some practical points which relate to the current legal situation and to the doctor's conscience in the matter of abortion. The scientific data are Dr. Hellegers'; the pastoral observations are my own.

It takes several hours, say six or eight, for the sperm to be "capacitated" so that it can fertilize an ovum.

The fertilized ovum, sometimes called the diploid zygote, is an entirely new genetic package, having within itself one half of the hereditary characteristics of the father and one half of the mother. Theories concerning the time of origin of personhood should take this genetic picture into due consideration.

The fertilized egg, starting as a single cell, develops in the fallopian tube for six or seven days, during which time it divides, first into two cells, then four, then eight, etc., at the rate of almost one division a day, thus forming a sphere of cells.

After six or seven days, the sphere of cells enters the uterus. In the meantime, and until the fourteenth day, the sphere of cells may split into two identical parts, ultimately to form identical twins. The two spheres of cells may also recombine into a single unit. After the fourteenth day, conjoined twins, representing distinct fertilizations, may still be produced. Theories concerning the time of the origin of personhood, namely, the moment of hominisation and ensoulment, should give careful consideration to the phenomena of twinning and recombining.

In the uterus, one pole of the sphere of cells burrows into the lining of the uterus and is called the trophoblast. The trophoblast becomes the placenta and produces hormones which enter the blood stream of the mother, arrest menstruation, and show up in pregnancy tests, thus giving the first positive proof of pregnancy.

In the embryo, organs become increasingly differentiated. Between the third and fourth week, heart pumping occurs. At the end of six weeks, all organs are present in a rudimentary stage. At the end of eight weeks, there is readable electrical activity coming from the brain, and the embryo is called a fetus. After 12 weeks, the brain structure is complete.

Through the twentieth week, delivery of the product of conception is called an abortion. By definition, the product of an abortion cannot live. Between the twentieth and twenty-eighth week, delivery of the fetus is called a premature delivery, during which time the fetus has about a 10 per cent chance of survival, which increases with the passage of time.

The mother, her doctor, society and the church all have a legitimate interest in, and responsibility for, the unborn child at all stages of its development. The tradition of western civilization has been to protect unborn human life by making abortion an illegal, criminal procedure, except in certain specified circumstances, which are not considered here. Today, we are witnessing a widespread relaxation of this tradition, the extreme form of which makes abortion subject only to the decision of an expectant mother and her doctor, under the provisions of "abortion on demand" legislation, which has been considered for enactment by our state legislature. The fact that the

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Catholic Diocese of Natchez—Jackson.

pregnant mother is frequently under great emotional stress, so that she tends to change her mind and to regret her decisions, places an added responsibility upon the doctor.

Physicians and surgeons occupy a unique place in our culture. Especially among the meek, the defenseless and the poor, doctors are held in a reverence and esteem which, in former times, was reserved for the prophets and the saints. This status is passing, but it is with us still. Men and women who are so reverenced simply must realize the magnitude of their responsibility.

In former times, attitudes towards the unborn child were formed without the biological information we have today. Even today there are schools of thought which close their eyes to modern information on pre-natal development, to the responsibilities of the state to defend the defenseless, and of the Church to speak up for the rights of God and of conscience in determining the right to life of the unborn child.

Men and women of the medical profession should furnish the leadership in opposing "abortion on demand" laws. Failure to do so could open the floodgates to anguish of conscience and demoralization for doctors, nurses and hospital staffs in our state.

Our society needs a profound and widespread spiritual awakening. Fundamental to such an awakening will be the recognition of God as the Maker, the Master and the Goal of human life. "Abortion on Demand" laws strike at such recognition. ★★★

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Key participants in the Seminar on Moral Aspects of Abortion discuss the issues. From left, standing, are: Dr. Henry A. Thiede, Jackson, UMC professor and chairman of obstetrics and gynecology; The Reverend Edwin R. Wilson, Pastor of Fondren Presbyterian Church, Jackson; Dr. John M. Alford of Greenwood, MSMA Committee on Medicine and Religion chairman; Rabbi Perry E. Nussbaum, Beth Israel Congregation, Jackson; and seated, The Right Reverend Monsignor Josiah G. Chatham, Catholic Diocese of Natchez—Jackson.

A Rabbi's View

PERRY E. NUSSBAUM, D.D., D.H.L.
Jackson, Mississippi

IT MUST BE OBSERVED at the outset that before considering Judaism's attitudes on social issues one must understand a fact or two about its historical development. Judaism is a religion which does not depend on a monolithic structure. "Synagogue" and "Church" are not synonymous concepts in the Paulinian sense. There is no creed to which every true Jew is obligated. Thus Jewish literature and all efforts to codify religious legalisms are less "the law" than compendiums of rabbinic opinions and judgments founded on individual insight. The end result often has been mutually contradictory positions, even when stated "authoritatively."

This is an oversimplification of an involved subject but is noted here to emphasize Judaism's dominant principle, established with the ancients, that the spiritual development of man is evolutionary. That principle still persists. A fundamentalist (i.e., Orthodox) Jew, of course, rejects it completely or admits it partially. His brethren in the Faith, best categorized as non-orthodox (more formally, Conservative or Reform) accept the principle and implement it in varying degrees.

It is necessary, therefore, for this writer to identify himself as a Reform (also known as Liberal) rabbi. His "school" is prepared to disregard those elements from the past which are not relevant to the present and future needs of man, which are out of tune with modern science and out of step with the fresh moral insights of the age. Theology, to the liberal, is no longer the "Queen of the sciences."

From this perspective, the remarkable feature about the issue of abortion is that it has not been discussed very much in historical Jewish literature. Criminal abortion, contrary to a misinterpretation of Exodus XXI:22-23 by the Greek Septuagint which had such profound influence on early Christian dogma, is not dealt with in the Old Testament. Moreover, the vast library of commentaries on Scripture which fixed the "Law" is rarely concerned with our subject. Such silence, says Dr. Immanuel Jakobovits, currently Chief Rabbi of the British Commonwealth of Nations and a leading authority on Orthodoxy, is to be explained by the fact that "foeticide was virtually nonexistent in Jewish society at any time."

This is not to say that Jewish physicians from the earliest times did not practice therapeutic abortion. The moral element was never absent from their views about healing and saving human life. Again at the risk of oversimplification, it may be said that the early rabbis did not deprecate the theological importance of the soul when the question arose about the exact moment in time it enters the foetus and establishes a new human entity. But they were also concerned with the preservation of existing human life. Thus, in the instance of pregnancy, a paramount concern was the life of the expectant mother. We see such concern reflected in agreement and disagreement from the period of the Mishnah (edited about 220 A.D., the beginning of the Talmud), explicitly formulated by the renowned Moses Maimonides of the 12th century—philosopher, theologian, legal codifier, and eminent physician—and finally established as religious law in 1565 in the *Shulhan Arukh* (The Prepared Table), which is still the authoritative code of spiritual and moral conduct for Orthodoxy.

The principle is as follows: "If a woman is in hard travail, one cuts up the child within her womb and extracts it member by member, because her life has priority over its life; but if the greater part of it [at least the head] was already born, it may not be touched, since one does not set aside one life for the sake of another." The appearance of the head revealed "life," although there were opinions that sometimes it could not be proven until at least a month after parturition

Temple Beth Israel Congregation.

in exceptional cases. The reasoning behind this principle was that the embryo is part of the mother and not a separate human being. The point at issue, and resultant differences of opinion, was at what time the foetus would be so considered, as there were disagreements about the presence of the "soul" in the foetus, or the fate of that "soul" in the next world, if the foetus were aborted.

What I am attempting to establish in this limited presentation is that until modern times a principle which can be called moral was present, but attitudes about its application were not firm, a reflection of the historic evolutionary mood. Judaism is primarily "of this world" in its emphases, and is constantly on the search for the wellbeing of God's creatures on this earth. Inevitable changing needs and circumstances, therefore, would persistently challenge so-called tradition. Abortion was not exempt. To which must be added that the principle did not justify abortion on economic, psychological or social grounds.

Modern circumstances are witnessing more evolution. Although, in general, Orthodoxy is still opposed to other than therapeutic abortion, and even then only when protected by rigid safeguards, the late Sephardic Chief Rabbi of Palestine (very Orthodox) decided in the case of a woman who was threatened with permanent deafness if she went to full term, that no sin was involved in destroying the "lifeless" foetus for her sake.

Dr. Solomon B. Freehof, a leading Reform Rabbi of this generation, has written in connection with the problem of a pregnant woman with German measles that when "there is strong preponderance of medical opinion that the child will be born imperfect physically and even mentally, then for the *mother's sake* she may sacrifice part of herself."

This latter position is a clear expression of liberal Judaism's socio-psychological attitude in issues too often beclouded by obstinate reliance on the tradition. The liberal rabbi, therefore, is prepared and often eager to further liberalization of state laws about abortion. He finds no difficulty in modifying longheld theological definitions about "viability," "rationality," "soul," "life." He welcomes the investigations of contemporary science, because the facts of life in the 20th century contain social challenges which biblical authors could hardly anticipate. Furthermore, he proceeds from a conviction in progressive revelation, that the legalisms produced by historical religion must be relevant to social crises, whatever their nature, and in the name of Deity.

No one will deny that since 1962 and Thalidomide, the problem of abortion has not been brought into serious community focus. Consequently, liberal Jews reject any attempt, albeit religiously motivated, to equate abortion with crimes against God and nature, and certainly reject the imposition of any particularized set of dogma about it on the entire body politic. The common social concern is basic to moral principles and no religion has a monopoly.

That any liberalization of state laws on abortion will lead inevitably to "abortion on demand," "infanticide" or a "do-it-yourself" pill, begs the moral question: how to reduce one million criminal abortions performed annually in this country, mostly by unqualified persons. Obviously, it is to be deplored that American society is being afflicted with a variety of moral problems, but muddying the waters of liberalized legislation about abortion is hardly appropriate. The female to whom pregnancy has become a misfortune, or the doctor conscientiously alert to keeping pace with the times, are not helped at all.

If I began on the note of understanding where Judaism differs at times from other religious particularisms, permit me to end on this note: Jewish tradition has the highest respect for the physician. It supports the highest of medical ethics. Medicine, to Judalism, is "the perfect mixture of science, art and ethics." That many of today's physicians have become ambivalent about their role in abortion is perfectly understandable. Any clergyman must empathize, and sympathize with the professional who dislikes "playing God" when life and death are involved, and decision making becomes of prime importance. But, as in other decisive stages in the history of medicine when its practitioners were put to the test and not found wanting, today's doctors will bring to bear their knowledge and skills, their insights into the nature of man, as well as their own moral values and religious heritage, when confronted with the prospect of aborting. There need not be "abortion mills" when legislation accents the moral elements. The least the state can do is to remove outmoded stigmas of illegality now that the medical profession has risen forthrightedly to an overdue assessment of its responsibilities in a crucial area. It should be added that a singular fact of contemporary American life—long may it endure! —forces no doctor to practice what his conscience abhors. This in itself is one of the great moral principles which will preserve our American society.

In summary, the Central Conference of American Rabbis (this writer's national Jewish association) adopted the following resolution in 1967:

"(1) The CCAR considers as religiously valid and humane such new legislation that:

a) recognizes the preservation of a mother's emotional health to be as important as her physical well-being; and

b) properly considers the danger of anticipated physical or mental damage; and

c) permits abortion in pregnancies resulting from sexual crime including rape, statutory rape, and incest.

"(2) We strongly urge the broad liberalization of abortion laws in the various states, and call upon our members to work toward this end."

Similar resolutions have been passed by the Union of American Hebrew Congregations and the United Synagogue of America, the lay national bodies of Reform and Conservative Judaism. Orthodox Jewish groups are not in agreement.

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Seminar on Abortion

A Physician's View

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THE PHYSICIAN PRACTICING medicine is guided by a moral code of ethical and legal standards. When therapeutic interruption of human pregnancy is under consideration, however, the ethical and legal aspects are sometimes in conflict. The medical indications for abortion may be perfectly clear, but state and local statutes often make it illegal to pursue the dictates of ethical medical practice. Legal statutes are rules of conduct for the social community. Therein lies the doctor's dilemma. Is the physician responsible to the community, the parents, the unborn child, mankind or our Creator? It is all, of course, and the real moral issue is how to satisfy the requirements of the entire group.

Every state permits abortion to preserve the life of the mother. These occasions are uncommon, and in general, include such medical problems as severe renal, cardiopulmonary or metabolic disorders; cancer of the reproductive organs; and rarely, psychiatric disease. Only 16 states permit abortion to preserve the mother's health.

Professor and Chairman, Department of Obstetrics and Gynecology, University of Mississippi School of Medicine.

In recent months, we saw a patient with severe chronic kidney disease who was eight weeks pregnant. Her renal function in the non-pregnant state had stabilized during the previous year in an uneasy equilibrium between barely adequate and frank uremia. The odds were overwhelming that she would not carry her pregnancy to a successful conclusion and also that the additional burden of the pregnancy on her kidney function would cause further irreversible damage. Early interruption of her pregnancy would prevent the added kidney damage, but by state law this would be illegal. A similar case occurred in which pregnancy in a patient with severe diabetic retinopathy tipped the balance from partial sightedness to total blindness. Abortion could not be done to preserve the health of the mother. What are the moral obligations of the physician in these types of cases?

The other end of the spectrum is the inconvenient pregnancy, the out-of-wedlock pregnancy or the unplanned pregnancy that brings serious financial or emotional hardship. Should a 12-year-old child be forced to complete a pregnancy conceived in ignorance or innocence? If not, at what age should the line be drawn? Should the

emotionally immature, irresponsible couple that doesn't want children be required to continue a gestation? The incidence of abuse of unwanted children is growing at an alarming rate. The unprofessional commercialism of abortion on demand as practiced in some areas is unacceptable to most physicians, but there is clearly a need for freedom to handle the problems of the individual patient according to the best ethical judgment of the medical community wherein she resides.

The physician may have a moral obligation to the fetus. It is possible to diagnose with precision in early pregnancy fetal malformations such as Mongolism and certain serious familial metabolic disorders. Furthermore, we know that maternal Rubella in the first four weeks of gestation means at least a 50 per cent chance of giving birth to a child with serious multiple deformities. Is it the responsibility of the physician to terminate these gestations before viability because of the anguish the child will suffer? Many physicians think so and they are also mindful of the tremendous financial and emotional burdens parents must assume in rearing a mentally and/or physically defective child.

The eugenic aspects of therapeutic abortion are just as pertinent. Selective abortion can prevent the perpetuation of certain heritable disorders such as some types of progressive muscular dystrophy, insanity and malignant tumors as well as sex-linked inborn errors of metabolism.

Does the medical profession have moral obligations to society? The population explosion is already presenting problems of waste disposal, diminishing natural resources and overcrowded recreational facilities. Although this is as much a political issue as a moral one, the physician must consider his social responsibility when he is confronted by an unwanted pregnancy, especially when it is apparent that the child will be born to live in abject poverty with repeated exposure to starvation, disease and suffering.

Scientific progress has made it possible to determine early in pregnancy the existence of many serious, uncorrectable fetal disorders, and has made it possible to perform abortion with relative ease and safety, but it hasn't yet devised a means of accurately determining the fetal age in utero. One theological consideration might be the gestational age beyond which pregnancy ought not be interrupted, except to save the life of the mother. Medically speaking, 22 weeks post-fertilization seems to be a logical upper limit.

In summary, the moral aspects of abortion involve ethical and legal standards. The legal provisions for abortion, however, have not kept pace with advances in the medical sciences. Liberalization of the abortion laws is essential for continued sociomedical progress. The question is only how liberal. Adequate standards for safe abortion must be developed in Mississippi that consider the problems of indications for abortion, consent, residency requirements, conscience clause, constitutional rights, time during which abortion is permissible, the place where it may be performed and by whom. Equally important is how to provide these services to persons of all socioeconomical levels. Surely the best solution can be obtained through the cooperative collaboration of the medical, legal and theological sciences. ★★★

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ADDENDUM

The Committee on Medicine and Religion and the Editors regret that the excellent and illuminating paper delivered to the seminar by the Rev. Dr. Edwin R. Wilson of Jackson, pastor of the Fondren Presbyterian Church, was not available for publication.—The Editors.

Radiologic Seminar CV
Computer Dosimetry: A Significant Contribution to Radiation Therapy

W. M. FLOWERS, JR., M.D.
Jackson, Mississippi

AGGRESSIVE RADIATION therapy directed at cure rather than palliation of malignant disease demands the most sophisticated, accurate, and precise dosimetry calculations possible. Until quite recently, such information could be obtained only at a very few of the large, specialized cancer hospitals such as the M. D. Anderson Hospital in Houston, Texas. This is no longer the case. The department of radiology at the University of Mississippi Medical Center has now developed a version of RADCOMP II;[1] an extremely powerful computer program that will produce detailed drawings of the radiation levels about radioactive sources within a patient undergoing radium therapy. This is possible with the IBM System 360/40 computer available to us through the Mississippi Research and Development Center and special plotting equipment presently furnished by the Mississippi Regional Medical Program.

A radium application for carcinoma of the cervix is an example of the need for such a program. Prior to computer dosimetry, it was practical to calculate the dosage to only a very small number of isolated points, and calculations were made to determine the time necessary to deliver the correct number of rads to these points. All other positions within the range of the implant were assumed to receive an acceptable dosage; further calculations were not only cumbersome, tedious, and relatively inaccurate, but the calculations had to be made by hand, and the sheer number necessary quickly became prohibitive.

A radium implant is seldom perfect or symmetrical; in any such implant, areas of local underdose or overdose are possible and it is obvious that failure to detect these areas has serious consequences. Often they cannot be appreciated by simply looking at the radiographs of the implant. The digital computer and its associated plotting equipment has changed this situation considerably. It is fully capable of producing plots that provide accurate, thorough, and complete dosage information quickly, economically, and with a minimum of effort.

This technique has also furnished a foundation for support of future research projects; such as study of tumor recurrence and radiation compli-

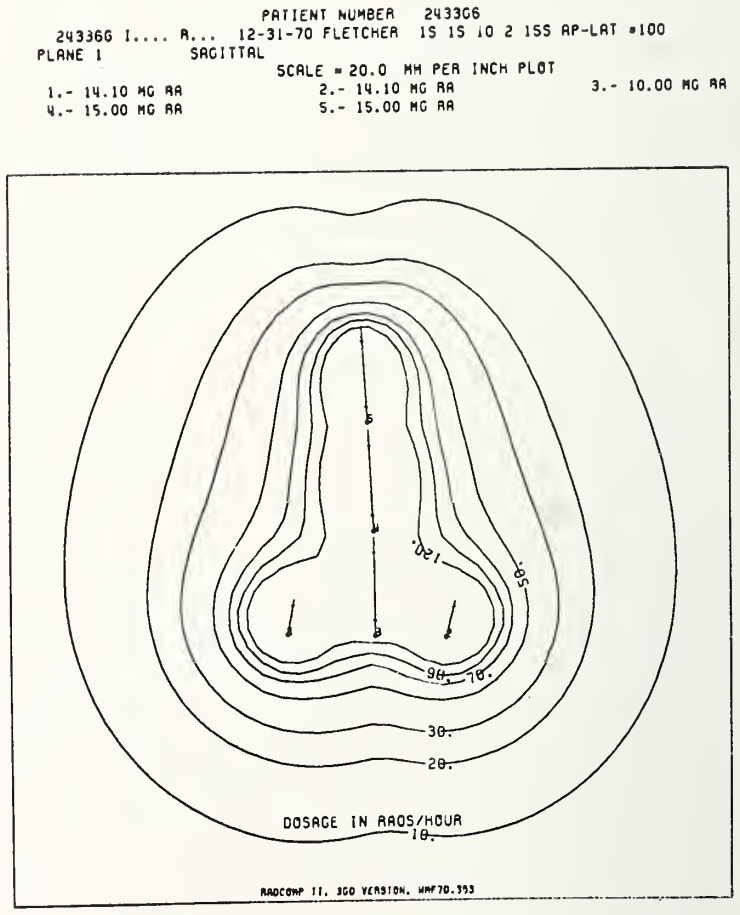


Figure 1. Computer plot of Fletcher applicator used for treatment of carcinoma of the cervix, anterior projection.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi School of Medicine.

cations, comparison of results of different methods of therapy, and study of possible improvement in cancer cure rates. It is capable of simulation of radium applications for teaching purposes or for treatment planning, and we will soon have a library of isodose curves in our medical center for various treatment configurations.

The use of this new system is not limited to the University Medical Center. Through the Mississippi Regional Medical Program, we are able to offer this service to all radiologists, gynecologists, and other qualified physicians in our region. Requirements are modest; localization radiographs using relatively simple marking devices and the specifications of the radiation sources. The only charge to the patient is nominal: $25 for the computer time. Consultation services are available and the user need have no knowledge whatsoever of computers, computer facilities or computer programs.

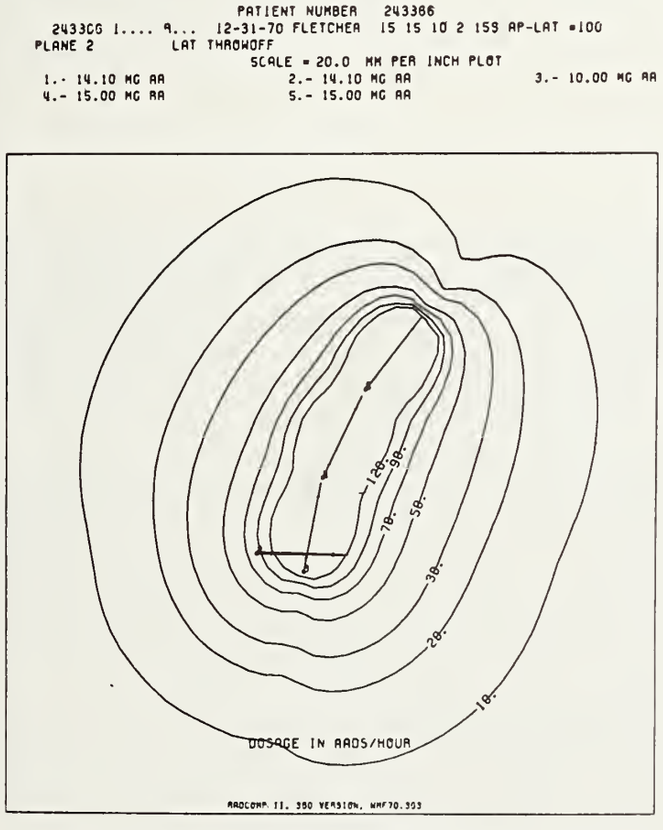


Figure 2. Computer plot of Fletcher applicator used for treatment of carcinoma of the cervix, lateral projection.

To those who appreciate the enormous importance of accurate and complete knowledge of radiation dose distributions in patients with malignant disease, the digital computer can produce technical results that are no less than spectacular, but spectacular technical results are not the primary objectives of radiation therapy.

The most important consideration is the clinical usefulness of the detailed information that a computer can produce for the physician and for his patients. It is perhaps premature to state that

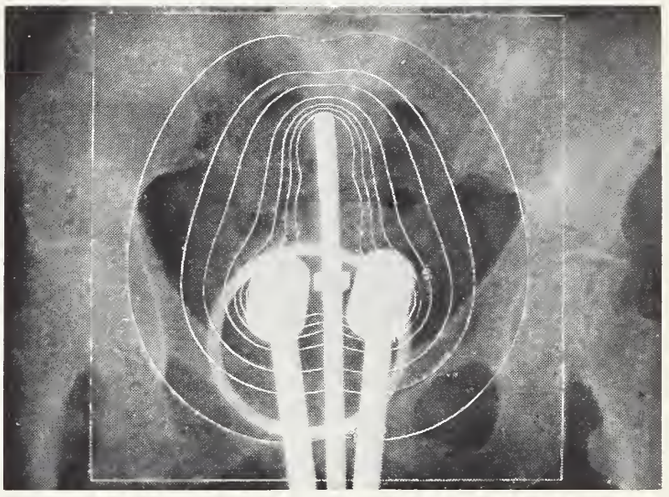


Figure 3. Radiograph with superimposition of isodose contours from computer plot on the Fletcher applicator, anterior projection.

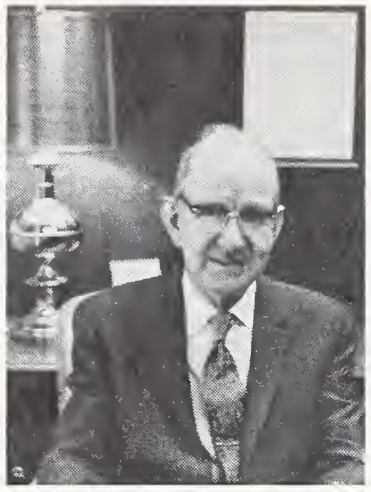
cure rates can be improved by the availability of more decisive dosage information, but a retrospective study[4] was done in cases chosen because of local recurrence or necrosis, and more than two-thirds of the complications could be explained on the basis of local underdose or overdose as revealed by complete isodose distributions. The objectives are clear; an increased number of cures; a decreased number of recurrences, complications and failures. ★★★

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Supported in part by USPHS Grant 5 GO3 RM00057-02 Health Services and Mental Health Association.

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The President Speaking

"Who Said So?"

PAUL B. BRUMBY, M.D.
Lexington, Mississippi

WE HAVE HEARD repeatedly throughout the past few years of the sad state of American medicine and its delivery. The basis of this criticism is a report of statistics presented by the World Health Organization showing our infant mortality as being the 12th among developed nations. How many times upon hearing this quoted have you asked yourself, "Who said so"?

Resolution 43 at the last AMA meeting was bitterly discussed because of the acceptance of these figures even by governmental agencies. The World Health Organization accepted the statistics presented by each nation. This organization is known as no friend of the private practice of medicine, or the American way of life. They did admit that there were no criteria or definition which were accepted by all nations included in this study.

At the recent White House Conference on Children and Youth, these statistics were glibly quoted by men who must have known of this discrepancy. There is no universally accepted definition of an embryo, fetus, or a fetal or infant death. Here in the United States, we must report the death regardless of period of gestation, the weight or the development of the fetus, and it is an infant mortality if it moves a muscle, breathes, or there is pulsation of the cord.

In reporting there are as many methods as there are nations. Here we must report from the hospital or from our office, under penalty, every birth and death immediately. Scandinavian law permits infant registration within five years without penalty. Please remember at the end of five years, many small infants are well forgotten, while live children are very much in evidence. These are the countries with which we are adversely compared. So we ask again, "Who said so?" ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 3

MARCH 1971

EDITORIALS

Some Radiology Problems in Community Hospitals

JOSEPH C. GRIFFING, M.D.
Picayune, Mississippi

I BELIEVE THE MAIN problem radiologists face in small hospitals is a communications gap with patients and other physicians. The shortage of medical personnel accounts for most of this gap. We are just too busy to communicate effectively.

Yet if a radiologist is to produce significant information about a patient's illness, he must know something about the patient. This is fundamental. The quality of any radiology report drops sharply in the absence of the history.

An EKG is almost a meaningless squiggle without clinical findings. Similarly, an x-ray is a mere transparency without the history. The radiologist can search out clinical information on his own initiative. But why search? The clinician should provide the history. It's his patient. I've never seen an instance where too much was known about a patient but many cases where not enough was known.

About 40 per cent of all crucial medical decisions depend on the radiological examination. The life of the patient may rest squarely on these findings. So it's important to have the right clinical information in order to do the x-ray study properly.

Some doctors place too much faith in the x-ray report and others not enough. A fatal mistake is blind faith in any consultant, regardless of his title. In my judgment, many doctors rely too heavily on the x-rays. Some physicians (radiologists included) lack the ability or confidence to make a diagnosis by themselves.

The recent technical explosion has produced a bonanza of new tools for radiologists. The catheters, isotopes and television give us the means to explore every nook and cranny in the body. We've unwittingly given the impression that we can diagnose anything under the sun. It is not so. Maybe we've oversold radiology in what it can do for the patient. I'm afraid we've badly oversold it.

Actually, it will take several years to learn how to best use the hardware we have now. For example, pulmonary embolism causes many deaths and is present in about 60 per cent of autopsies. Thromboembolism is one of the vast blind spots in medicine today. Which is preferable —a chest x-ray, lung scan or angiogram? Nobody really knows. We do know that you must suspect an embolism before you can diagnose it.

A perceptive clinician with his black bag can generate more information about a patient than any x-ray or lab test. He uses these services to confirm or deny his suspicions. The sophisticated clinician has every right to be cranky. I admire his courage.

From the Department of Radiology, Lucius Olen Crosby Memorial Hospital.

X-ray studies are meant to augment and expand physical examinations. They are not meant to replace physicals. Multiphasic lab testing and x-rays have become so routine, however, that I suspect they're becoming subtle substitutes for physical examination.

This proliferation of "routines" causes radiologists and pathologists to spend an awful lot of time documenting negatives and trivialities. Many Mondays are wasted documenting routine accident films from the weekend. No doubt this time could be better spent elsewhere. We don't have enough physicians to waste their time on trivialities. A few negatives, yes. Trivia, no.

Can we influence the natural course of disease by early detection campaigns? Nobody knows. We do know that traditional methods for check-ups waste a great deal of our time.

Computers and medical assistants will eventually be widely used to screen patients. It will take many years, however, to hack through the legal snares and medical-surgical obstructions to reach higher ground. Computers should prove especially valuable for record keeping. Then our much sought-after negatives will be only tiny blips on a tape.

Patients referred to distant hospitals pose a special problem. First, they inevitably take their x-rays and secondly, the local radiologist never learns the outcome of these cases. It's a wretched dilemma. Our best cases wind up in the other fellow's teaching file.

The correct diagnosis is always made in the other hospital. Nobody likes to see the home team routed but let's face facts. That big hospital down the road has the expertise and equipment. There's no point in stewing over excuses or getting paranoid about it—expertise and equipment are all that's needed. And, of course, there's always a bigger hospital, or a bigger clinic, someplace down the road.

A freshman radiologist in a community hospital may inherit an image problem. He is often looked upon as a supertechnician minding a photo shop rather than a physician consultant. Administrators, in particular, like this image. Some would deny him license, keeping him in a back room mumbling about things of greater or lesser density. It's an old saw and one easily broken. Eventually he will make the diagnosis of things rare and completely unexpected. Then the image business takes care of itself. Nothing talks better than a hefty batting average.

Community hospital radiologists have trouble finding capable professional and technical help. To do the patients justice, good help is an absolute necessity. A capable technician is 10 times more valuable than his equipment. It's impossible to do meticulous and exacting work with poor help.

Combination lab and x-ray technicians have gone by the boards. They brought joy to the administrators while they lasted but they've fallen victim of the technical revolution. Given a choice between a bright young technician or one with experience, I prefer experience. Young folks sometimes kick over the traces like young mules.

We are almost as short of conscientious employees as we are of radiologists. A true craftsman who sticks on the job is rare indeed. Nine times out of 10, a medical assistant hired for a particular job won't be at the same post three years later. Many won't be on the job three months later. It often boils down to money.

Another money problem involves equipment. Few hospitals are overequipped; many are underequipped. Technology is changing so fast, new equipment may be almost outdated by the time it is installed. The image amplifier and automatic film processer have earned their place of value alongside Roentgen's tubes.



"It'll just be a moment, Mrs. Mumford. . . . Doctor is reviewing your symptoms."

Finally, a serious problem is unnecessary or wasted x-rays. About 30 per cent of our work is based on anxiety, either on the part of the patient, his doctor or his lawyer. As long as people have anxieties, I imagine this will continue.

If we could eliminate some of the wasted x-rays, follow-ups and unnecessary checkups, we would have time to do a better job for sick folks. All of us would have more time to think. I believe patients, doctors and hospitals would all be better off. ★★★

1521 Fifth Avenue (39466)

The Hospital's Unique Economic Personality

More frequently than not, it is generally agreed that the hospital is the villain in medical care costs. In two decades, the cost of hospital care has risen more than 200 per cent. The annual mean has hovered between 6 and 7 per cent of increase, but hikes in one year of as much as 16 per cent have been recorded.

This is not, emphatically, a damnation of hospitals, their management, or their posture in the health care picture. These editorial columns have championed the hospital on a good many more occasions than they have remonstrated with it for any reason. But certain facts are more than self-evident:

—The rate of cost increase in hospital care is unmatched by any other component of the total health care delivery system.

—As more and more billions in public funds are dedicated to purchase of medical care, the hospital invariably comes in for the major share by the very nature of its unique economic personality.

—In comparison with the typical business enterprise of a corporate nature, the hospital is hideously inefficient.

Grave charges? Yes, if taken out of context and used in defense of a patently bad organization and management circumstance. But if accepted and understood in the constructive spirit in which they are offered, then these are pertinent observations affecting not only the center of health care but every member of the health care team as well. After all hospitals aren't the enemy; the enemy is disease.

The rate of cost increase in hospital services speaks for itself in quantitative terms. It has happened, and it is there. The why of the matter is something else, and this leads to examination of the other two observations.

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Since Jan. 1, 1966, just under $30 billion has been expended for Medicare and Medicaid caring for citizens selected on the criterion of chronological age for Medicare and economic status for Medicaid. They account for about 18 per cent of the population, just over one out of six Americans. Of all the billions poured out in these programs, 11 per cent has been paid to physicians, while 88 per cent has been paid to hospitals, nursing homes, pharmacists, and others. But the hospitals received about half of this major nonprovider share.

Eli Ginzberg, professor of economics at Columbia University, describes the hospital as a multipurpose institution. He says it is:

—The locus of complicated levels of medical care.

—A reservoir of standby capacity for emergency needs.

—A locus for medical services for ambulatory patients.

—A major source of employment for millions of workers.

—The major working place for most health care professionals.

—A teaching and research institution.

—An institution where important innovations and developments occur.

—An institution which attracts the active participation of certain lay leaders.

Dr. Ginzberg says that given these varied dimensions, "it should be clear that one cannot deal in any simple-minded fashion with hospital inputs or outputs.

"For the patient, the hospital may be critical as regards his therapy. For many who work in the hospital, it is a job and income. The professional may be interested in the hospital for clinical, research, or training reasons—or for all three. And few people really see the hospital through the eyes of a manager, an administrator, or a director (trustee)."

Dr. Ginzberg reminds us of Roemer's Law, said to have been formulated in the 1950's: Whenever hospital beds are available, they tend to be used. He argues for tight controls over hospital capacity and pre-expenditure controls as crucial in holding a rein on cost factors.

He also says that as more government money becomes available to hospitals, there is a tendency to expand and elaborate existing services and to enter new areas with purchase of expensive equipment and employment of more personnel. Supporting this assertion, Dr. Ginzberg says:

"The most serious consequence of the federal government pumping $6 billion annually (1970) into general hospitals is that hospital administrators who had always been concerned about deficits suddenly decided that they were on easy street and did not have to worry about money any more. They began to approve all kinds of requests for expensive equipment, services, and the like. Since they could be reimbursed for all of the costs, and initially earn a few per cent above that, all constraints were removed."

This opens the door to examine the hospital as an efficient or inefficient economic unit in a nation noted for corporate efficiency. In defense of the hospital, it is generally not intended as a moneymaking entity, although some few are and do. It has even been said with good-natured levity that the hospital is like a huge department store where the merchandise is purchased by accident, the customers are hauled in against their will, and that the entire place is run by a bunch of outsiders over which the real management has no control.

Moreover, hospitals are labor-heavy on the cost side: Every dollar that comes in must yield up 60 to 70 cents for people, and everything else must be run on what's left. In contrast, the typical manufacturing business in the United States spends 26 per cent of its total costs on labor. Here again, the uniqueness of the hospital is succinctly underscored.

But Dr. Ginzberg has a few other examples. He writes of the testimony of a leading hospital administrator before a New York state legislative committee "who boasted of the fact that whenever they discover that a newly admitted patient has high blood pressure, they automatically submit him to a series of tests which cost $700.

"I submit that this is bad medicine and impossible economics," Dr. Ginzberg declares.

Conceding that the hospital cannot be compared to a manufacturing operation, Dr. Ginzberg explains that the nature of the entity is such that hospital care permits relatively little substitution of machinery for men, meaning that immediate gains in productivity to the benefit of costs can only be modest. But he extends his assessment of fault to third parties by pointing out that insurance has been slow to experiment with outpatient benefits, and he says that improved hospital insurance is *per se* inflationary.

Ten years ago, this JOURNAL posed the question of progressive patient care, a phrase now probably forgotten, asking why every bed had to have maximum care capability when two-thirds of the census on a given day was not critically



"Now, Edna, you stood right there and heard him tell me to drink plenty of liquids!"

ill patients. Just today are hospitals coming around to this concept which was so successfully pioneered in their field 20 years ago.

Finally, Dr. Ginzberg says that "I am not very enthusiastic about the proposal which looks to influencing the professional staff in the hospitals as the principal method of cost control." He puts this task on the trustees and administrators, not as a matter of distrust of the physicians but as a proper duty of management.

Getting down to the nuts and bolts of the matter, Dr. Ginzberg calls for controls on third parties: "The incestuous marriage between Blue Cross and the hospitals must be broken up," he asserts. He would even place a ceiling on the percentage of annual increase in hospital costs and challenge the management to hew the line.

All of this seems to say that everybody—and especially physicians—with an interest in private health care delivery will do well to become better informed on health care economics. The physician is the easy and convenient target, because it is he who stands in the forefront carrying the responsibility. In addition, his professional compensation is on a *charge* basis, which, however reasonable, controlled by his peers or specialty, or otherwise restricted, is much more vulnerable to popular criticism than the hospital which is on a *cost* basis, however poorly managed, lavishly operated, or extravagant the institution may be.

And let it now be said, before somebody takes the foregoing paragraph apart from this whole as another slam from the medical establishment, it speaks of many physicians and few hospitals. There are opposites, too. But with costs and manpower the two crucial quantities in the health delivery equation, let's get on with the job of paring off the fat, delivering the care, and assuring the forward thrust of medical progress without the inevitable compounding of bureaucracy which the present state of things seems to invite.—R.B.K.

The Abortion Revolution: Inconsistent Change

The legal and moral issues surrounding abortion continue to be the centers of debate, even as the Mississippi Legislature considers amendments to the state's hopelessly outdated statute on the procedure. Within the past 12 months, the abortion laws of four states have been struck down by the courts, and the granddaddy decision of them all, that of the United States Supreme Court in *U.S. v. Vuitch,* is awaited.

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California courts struck down the state's 1967 "modernized" statute permitting abortion when a medical staff committee in an accredited hospital makes the determination that continuation of the pregnancy endangers the mother's health. The court said that this is an improper delegation of legislative power.

The Texas law, quite similar to the present Mississippi code, was stuck down under the Ninth Amendment which states that "the enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by the people." Thus, said the courts, women may choose whether they will bear children or not.

A three-judge federal court wiped out the Wisconsin statute on the grounds that a woman's right to carry an "unquickened" fetus—or the right to choose not to—transcends the "rights" of the fetus. The Illinois law was declared unconstitutional on the familiar grounds of being vague and nonspecific.

On the other side of the legal fence, a New York appellate court found for a physician who had refused to abort a pregnant patient even though she had been exposed to rubella. His hospital abortion committee was divided as to the medical necessity of the procedure, so he decided to decline. The child was born deformed, and the parents brought suit.

The appellate court held that the cause of action by an infant for failure to abort the mother is not cognizable at law. This is believed to be a landmark decision, because New York has the most liberal abortion law in the nation where failure to perform the procedure rests only with the physician.

What is now happening in the United States in abortion laws is a fragmented revolution of change. It involves medical policy, court decisions overturning long-established statutes, legislative change of law, liberalization of public policy, and new approaches to litigation. As the moral debate continues, the legal ruckus is producing a hodgepodge of situations, ranging from the anywhere, any time, on-demand New York climate to those states with sternly forbidding laws which have not yet been tested in the courts. The legal chaos will end only with a U. S. Supreme Court decision which obviously will not be to the satisfaction of all.—R.B.K.

New Partnership in Physician Placement

There is a new partnership in Mississippi, alive and well and working on the medical manpower shortage. The Ole Miss Medical Alumni Association and the state medical association have combined resources in a new version of their formerly separate Physicians Placement Services. Results? Better, we are sure.

For 10 years, the Office of Alumni Activities of the University Medical Center, ably administered by Charles William Price, has provided placement service and exchange information in behalf of Ole Miss medical alumni. This activity has been constructively extended into a major program supported by Ole Miss M.D. graduates.

In 1952, the state medical association initiated a Physicians Placement Service, originally begun as a means of getting the opportunity and the prospective physician-locatee together. In the early 1960's, a bulletin was initiated and published three times annually, but it was distributed only to those who had made inquiry to the association's service.

Just about everybody agrees that the shortage of physicians in Mississippi isn't made any better by maldistribution and blank spots on the medical map. Both the Ole Miss Medical Alumni office and the association's executive office agreed that a good efficient whole can be greater than the sum of its parts in physicians placement. The joint effort was formalized in early 1971, and the first joint bulletin, 10 pages long with almost 200 opportunities and M.D. listings, was published and distributed last month.

The new bulletin will be published quarterly and sent to all members of the medical association, Ole Miss medical alumni (with a system for avoiding duplicate mailing to alumni who are also members of MSMA), communities listing practice opportunities, and others who can be served. With each issue will be a form for listing practice opportunities or physician availability to relocate. The project is financed jointly by the alumni and medical associations.

We invite suggestions for improving the new service, comment, advice, and of course, any listings which may be sent to either of the sponsoring organizations. The entire idea is to serve you better.—R.B.K.

New Postage Stamp Salutes Blood Donors

January was Blood Donor Month, and President Nixon, who proclaimed the occasion nationally, is following up. The Postmaster General, Winton M. Blount, himself a blood donor, announced a special commemorative postage stamp to salute donors and stimulate participation in blood programs.

The 6 center will be issued March 12 in New York as the highlight of the International Philatelic Exhibition which will be in progress. "Giving Blood Saves Lives" is the theme of the stamp. For the philatelists among us, here are the technical details: The stamp is oriented horizontally as a poster type. The designer is Howard Munce of Westport, Conn., and red is the dominant color against blue. Three artists of the Bureau of Engraving and Printing, Edward P. Archer, Robert G. Culin, Sr., and Leonard E. Buckley, modeled the stamp and engraved the plates.

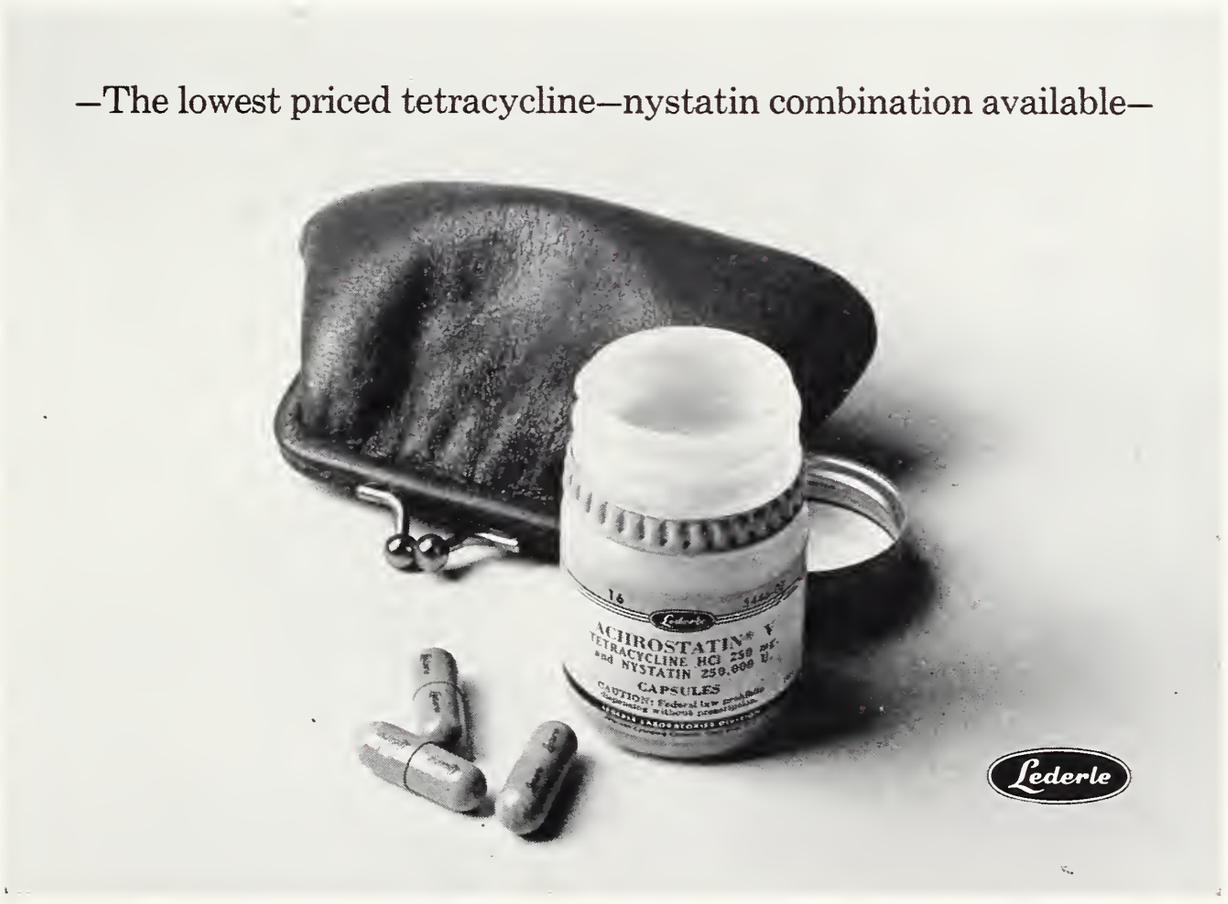
Postmaster General Blount, in announcing the issue, said that donation of blood is not keeping pace with need, and President Nixon has urged greater participation by Americans in blood programs.

Only 3 per cent of medically and legally eligible Americans give blood. The need has been critical in Mississippi, and Gov. Williams also proclaimed January as Blood Donor Month, although the proclamation was delayed by the legislative session until late in the month.

Representatives of the association and members of its Committee on Blood and Blood Banking have urged issuance of the postage stamp promoting blood programs. In France, a similar stamp is credited with trebling the amount of blood given in that nation.

So here is an idea for the entire health care team: Let those who use postage stamps instead of meters plan ahead and purchase regular needs after March 12, buying the new 6 cent blood donor commemorative. It is a project long overdue.—R.B.K.

—The lowest priced tetracycline—nystatin combination available—



POSTGRADUATE CALENDAR

UNIVERSITY MEDICAL CENTER POSTGRADUATE EDUCATION

March 24-26, 1971

EIGHTEENTH ANNUAL CARDIOVASCULAR SEMINAR

This three-day seminar at the University Medical Center is designed to give an overview of recent progress in therapy and management in the cardiology field, Dr. Gene Stollerman, medicine chairman at the University of Tennessee, and Dr. Anthony Demato, chief of cardiology at the U. S. Public Health Service Hospital, Staten Island, N. Y., are among the noted guest speakers. The Mississippi Heart Association and the University of Mississippi School of Medicine jointly sponsor the annual statewide seminar.

MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

March 8-12, 1971

NEPHROLOGY INTENSIVE COURSE
University of Mississippi School of Medicine
March 8-12, 1971, beginning at 8 a.m.

Sponsored by The University of Mississippi School of Medicine postgraduate education committee, with the support of the Mississippi Regional Medical Program

Coordinator:
John D. Bower, M.D., assistant professor of medicine and director, artificial kidney unit, The University of Mississippi School of Medicine.

Course registrants will study the reversible and treatable forms of kidney disease, with particular emphasis on management of acute failure and control of reversible features of chronic kidney disease. The course will also cover the management of pyelonephritis, fluid and electrolyte problems and acid base balance, as well as hemodialysis in clinical nephrology.

March 8-12, 1971

CARDIOLOGY INTENSIVE COURSE
University Medical Center, Jackson
March 8-12, 1971, beginning at 8 a.m.

New Nilcol- A Comprehensive Formula:

DESCRIPTION	Contents in mg Tablet	Elixir — each 15 ml
phenylpropanolamine HCl	50	25
chlorpheniramine maleate	4	2
glyceryl guaiacolate	200	100
dextromethorphan HBr	30	15
alcohol		10%

The scored, elliptical tablet is light violet. The elixir is deep violet in color and grape-flavored.

ACTIONS Each component of Nilcol has been selected to provide symptomatic relief of congestion and cough in upper respiratory disorders.

Phenylpropanolamine hydrochloride is a vasoconstrictor which reduces congestion of the nasopharyngeal mucosa. Chlorpheniramine maleate, a widely used antihistamine, helps to control allergic symptoms. The expectorant is glyceryl guaiacolate which helps to increase the secretion and decrease the viscosity of fluids of the respiratory tract. Dextromethorphan is a well-known, centrally acting antitussive. Nilcol may minimize the need for topical decongestants.

INDICATIONS Nilcol is indicated for nasal and bronchial congestion; coughs and other symptoms of respiratory infections including influenza and the common cold; other respiratory conditions such as sinusitis, allergic rhinitis or hay fever.

CONTRAINDICATION Hypersensitivity to any ingredient.

PRECAUTIONS Because of the possibility of drowsiness, patients should be cautioned against driving and operating machinery. Administer with caution to patients with hyperthyroidism, hypertensive cardiovascular disease, diabetes mellitus and liver disease. Use in pregnancy is not recommended.

ADVERSE REACTIONS Anxiety, restlessness, tension, insomnia, tremor, weakness, headache, vertigo, sweating, nausea, and vomiting may possibly occur.

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Sponsored by The University of Mississippi School of Medicine postgraduate education committee, with the support of the Mississippi Regional Medical Program.

Coordinator:
Patrick H. Lehan, M.D., professor of medicine and Mississippi Heart Association William D. Love memorial professor of cardiology, The University of Mississippi School of Medicine

Aimed at reviewing physicians with current concepts in bedside diagnosis of heart disease, this course features such cardiovascular aids as pulse tracings, phonocardiograms, electrocardiograms, x-rays and hemodynamic data. Participants will observe cardiac catheterizations and join in conferences.

Both one-week intensive courses, supported through the Mississippi Postgraduate Institute in the Medical Sciences by the Mississippi Regional Medical Program, are being offered for the second time this year. They are part of a series of courses offered to general practitioners from the class of 40 enrolled in the Institute.

CIRCUIT COURSES

Southern Circuit

Bay St. Louis—March 3—Session 3; Bay-Waveland Yacht Club, 6:30 p.m.
Hattiesburg—March 4—Session 3; Methodist Hospital, 6:30 p.m.
Session 3—Surgical Treatment of Coronary Artery Disease, Dr. Hilary Timmis
Current Practices in the Management of Chest Trauma, Dr. Richard Yelverton

Eastern Circuit

Meridian—March 9—Session 1; April 6—Session 2; East Mississippi State Hospital, 6:30 p.m.
Session 1—Management of Traumatic Renal Shutdown, Dr. Ben Johnson
Surgical Aspects of Urinary Trauma, Dr. W. Lamar Weems
Session 2—Diagnosis and Management of Rheumatoid Arthritis, Dr. Thomas E. Wilson
Mechanisms of Anemia, Dr. Francis Morrison

FUTURE CALENDAR

March 3, 1971
Circuit Course, Bay St. Louis

March 4
Circuit Course, Hattiesburg

March 5
Renal Seminar

March 8-12
Nephrology Intensive Course
Cardiology Intensive Course

March 9
Circuit Course, Meridian

March 24-26
Cardiovascular Seminar

April 5-9
Pediatrics Intensive Course

April 6
Circuit Course, Meridian

April 13
Circuit Course, McComb

April 19-23
Radiology Intensive Course

April 20
Circuit Course, Natchez

April 27
Circuit Course, McComb

May 3-6
Mississippi State Medical Association, Biloxi

May 11
Circuit Course, Meridian

Gulfport MACLD Invites Parents to Meeting

The Gulf Coast Chapter of the Mississippi Association for Children with Learning Disabilities has urged parents of children with serious learning problems to attend their meetings in Gulfport.

Dr. James A. Sheffield, a Gulfport pediatrician, president of the chapter, said such children have no physical damage to brain or body, but are often slow or hyperactive and are considered slow learners.

The state organization, at the local level, is attempting to plan special training for these children.

The officers urge all parents of children with learning disabilities to contact them and explain their problems.

NEW MEMBERS

MEGEHEE, JAMES ALFRED, Moss Point. Born Oxford, Miss., Aug. 6, 1943; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1968; interned Mobile General Hospital, Mobile, Ala., one year; general surgery residency, University Medical Center, Jackson, Miss., July 1, 1969-June 30, 1970; elected Dec. 14, 1970 by Singing River Medical Society.

DEATHS

FULTON, WARREN CARLTON, Aberdeen. M.D., University of Oklahoma School of Medicine, Oklahoma City, Okla., 1955; interned St. Joseph Hospital, Wichita, Kan., one year; surgery residency, same, July 1, 1956-July 1, 1957; died Jan. 11, 1971, age 50.

POHL, WILLIAM FREDERICK, Meridian. M.D., Jefferson Medical College, Philadelphia, Pa., 1923; interned Frankford Hospital, Philadelphia, Pa., one year; died Jan. 8, 1971, age 72.

PURSER, THOMAS, JR., McComb. M.D., Jefferson Medical College, Philadelphia, Pa., 1928; interned Employees' Hospital, Fairfield, Ala., one year; interned St. Vincent's Hospital, Birmingham, Ala., one year; psychiatry residency, University Medical Center, Jackson, Miss., April 1, 1959-June 30, 1962; secretary of Tri-Co. Medical Society, 1938-1939, Vice President, 1939-1940, and President, 1940-1941; died Jan. 24, 1971, age 65.

SWEAT, WILLIAM ANDREW, Jackson. M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1943; pathology internship, Lakeside Hospital, Cleveland, Ohio, one year; pathology residency, same, 1944-1945; surgery residency, Cincinnati General Hospital, 1947-1951; Diplomate, American Board of Surgery; died Dec., 1970, age 51.

WILSON, GEORGE MYRON, Gulfport. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1947; interned Charity Hospital, New Orleans, La., one year; psychiatry residency, University of Louisville, Louisville, Ky., July 1, 1957-July 1, 1960, Member, Board of Trustees, 1955-1957; died Jan. 16, 1971, age 47.

PERSONALS

CLINTON C. BATTLE of Clarksdale announces the reopening and relocation of his office for the practice of medicine and surgery at 1034 Garfield Street.

A. V. BEACHAM of Magnolia was appointed by Gov. John Bell Williams to the Hospital Care Commission for a term expiring in 1976.

G. LACEY BILES of Sumner, District 2, S. LAMAR BAILEY of Kosciusko, District 4, and G. LAMAR ARRINGTON of Meridian, District 5, were appointed by Gov. John Bell Williams to State Board of Health terms expiring in 1976.

HUGH L. BOYD of Ocean Springs announces the moving of his office on Washington Avenue to the clinic formerly occupied by FRANK O. SCHMIDT at 509 Jackson Avenue.

LAWRENCE H. BRISCO of Tupelo attended a recent conference on family practice at the University of California Irvine College of Medicine at Newport Beach.

ARTHUR E. BROWN of Columbus is currently president of the Mississippi division of the American Cancer Society. Dr. Brown attended the board meeting of the ACS Lowndes unit in Columbus recently and presented awards at that time.

JACK B. CAMPBELL and EDWARD M. LOWICKI of Jackson announce the opening of an additional office for the Mississippi Surgical Group at Suite 101, Medical Tower, 440 East Woodrow Wilson Drive. They limit their practice to general, thoracic, and cardiovascular surgery.

C. E. CATCHINGS, JR. of Woodville was named a director of the Commercial Bank at the annual meeting of the stockholders.

ALTON B. COBB of Jackson, WILLIAM L. JAQUITH of Whitfield, and REGINALD P. WHITE of Meridian were physician members of the health care team which recently visited the Georgia mental health facilities in Atlanta. They conducted an on-site review to study utilization of Medicaid in the support of mental health institutions.

HUGH B. COTTRELL and WARREN N. BELL of Jackson were appointed by VERNER S. HOLMES of McComb to a health manpower task force to assess health manpower needs and to develop a plan to meet these needs.

WALTER CRAWFORD of Tylertown received one of six coveted Silver Beaver Awards presented at the Andrew Jackson Council, Boy Scouts of America, appreciation banquet in Jackson. The award represents outstanding dedication and service to scouting.

WILLIAM R. FAIN of Jackson has received the Regional Medical Director's Award for Public Service in Communications. Dr. Fain received the award for his production of a medical motion picture, "Excision of Giant Emphysematous Pulmonary Bullae," at the Jackson VA Center.

C. LAURENCE FRANKLIN, formerly of Pascagoula, has announced that his Pascagoula office for the practice of dermatology and allergy is closed and the Mobile office at 729 Springhill Avenue is open on a full-time basis.

STEVE GEHRING and J. ROGER HALL have joined the Holly Springs general practice of MARION GREEN.

RAYMOND F. GRENFELL of Jackson was program moderator for the recent District 7 annual heart fund meeting. Dr. Grenfell is chairman of the MHA Research Grants and Fellowships Committee. Also on the program were W. C. HOLLAND and JULIA MULVIHILL, both from UMC.

JAMES D. HARDY of Jackson and UMC was guest speaker at a recent meeting in Natchez sponsored jointly by the Adams County Heart Association and the Natchez Jaycees. Dr. Hardy discussed recent advancements in cardiovascular surgery and pointed out how heart association funds are being used at the University Medical Center.

JAMES C. HAYS of Jackson has been appointed medical director of cardiology services at St. Dominic-Jackson Memorial Hospital. Dr. Hays is a graduate of the University of Mississippi School of Medicine and completed his residency at the Mayo Clinic.

ANSE B. HOWARD, III announces his association with the Medical Center in Louisville. Dr. Howard is a recent graduate of the University of Mississippi School of Medicine.

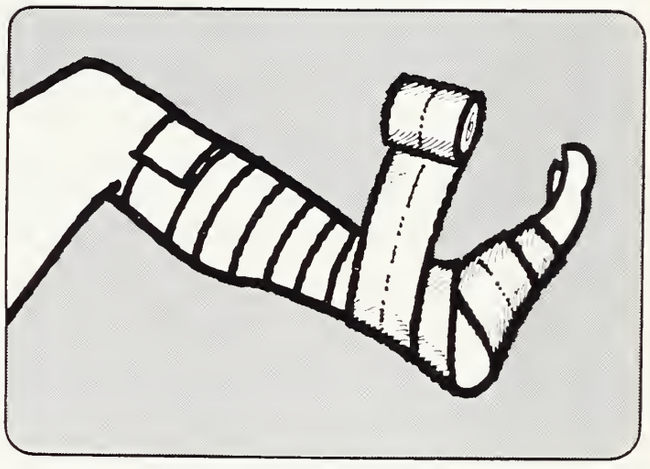
JOSEPH L. HURST of Jackson attended a cardiology seminar, "The Practicing Physician and Intensive Coronary Care," at Baptist Hospital in Nashville, Tenn. The weeklong seminar was sponsored by the American College of Cardiology and Cardiovascular Education Program of the Mid-South Regional Medical Program.

DAN T. KEEL, JR., of Brookhaven has been

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The Flexible Cast: The PRIMER medicated bandage, in conjunction with the FLEXOPLAST elastic adhesive bandage, comprise the cast.

This is a more comfortable and faster method of healing than Unna's Boot. Frequent changing of the dressing is eliminated. The newly forming granulation and epithelium are left undisturbed. It is the modern form of treatment.

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elected to the board of directors of the State Bank and Trust Company.

GEORGE T. KIMBROUGH of Hattiesburg announces the association of FRANK E. DEMENT, III for the practice of pediatrics in the Medical Arts Building.

WILLIAM E. LOTTERHOS of Jackson was on the program of the annual seminar on pastoral care of the ill, held at Mississippi Baptist Hospital in Jackson.

ELLIS M. MOFFITT of Jackson has been elected 1971 secretary of the Southeastern Region of the American Association for Clinical Immunology and Allergy.

J. ELMER NIX, B. G. SPELL, and SIDNEY R. BERRY, all of Jackson, announce the formation of the Jackson Orthopedic Group, Suite 408, Medical Arts Building in Jackson.

H. S. PHILLIPS of Holly Springs has been elected president of the Marshall County Hospital medical staff. Also elected were S. P. MCCLATCHY, vice president, and A. D. JONES, secretary.

JOHN C. POWELL of Senatobia has been named citizen of the Year for 1970 by the Senatobia Civitan Club. The award is given annually to a person who has made an outstanding contribution to the community.

JAMES E. SAFLEY of Brookhaven, director of the Lawrence County health department and six other county departments, has resigned and will assume the position of director of the Blood Plasma Center being established by Cutter Laboratories at the Louisiana State Penitentiary at Angola. Dr. and Mrs. Safley will continue to make their home in Brookhaven.

FRANK O. SCHMIDT of Ocean Springs has announced his retirement from the practice of medicine.

WILLIAM WAYNE SMITH, formerly of Groton, Conn., has moved to Holly Springs. Dr. Smith, a surgeon, will be associated with the Marshall County Hospital.

THOMAS E. STEVENS of Jackson has been awarded the distinguished service plaque by the Mississippi chapter of the Arthritis Foundation.

C. D. TAYLOR, JR., of Pass Christian, as chairman of the board of commissioners of the Pass Christian Housing Authority, accepted the key in recent official turn-key ceremonies marking the completion of a 90-modular-home building project that will provide permanent shelter for Hurricane Camille victims.

HILARY H. TIMMIS of Jackson and UMC was guest speaker at the first meeting of the Rush lecture series at Rush Foundation Hospital in Meridian. Dr. Timmis discussed myocardial revascularization.

ROBERT E. TYSON of Jackson discussed drug interactions encountered in medical practice at the recent special conference for pharmacists and physicians on drug interactions held in Jackson at Primos' Northgate Restaurant.

BILLY NEWMAN WATKINS, formerly of Brookhaven, has been appointed health officer of Pike County. Dr. Watkins, who will make his home in McComb, will serve the area including Amite and Walthall counties.

JOSEPH F. WELDY has joined the Vicksburg Clinic department of surgery.

UMC Institutes Division of Family Medicine

The University of Mississippi School of Medicine has created a Division of Family Medicine as a step toward family physician training programs. Dr. Robert S. Blount, University Medical Center, acting director and medical school acting dean, made the announcement in January.

The new division will function within the Department of Medicine, with direct emphasis on comprehensive family health care. Aim is to help meet the critical instate health manpower shortage through the "family doctor" concept.

Mississippi general practitioners who hold certification in the new family practice specialty have been appointed to the faculty.

"Doctors who have been in general practice at least eight years may now write American Board of Family Practice examinations to qualify as a specialist in family medicine," explained Dr. Blount. "Young physicians must complete three years training beyond medical school. We're working to develop both undergraduate and residency programs, with the help of state family medicine specialists."

"More physicians in family practice," he added, "are needed across the nation, especially in Mississippi. They can make a great contribution in relieving the state's physician manpower shortage."

Book Reviews

Extracranial Occlusive Cerebrovascular Disease. By Edwin J. Wylie, M.D., and William K. Ehrenfeld, M.D. 231 pages with 124 illustrations. Philadelphia: W. B. Saunders Company, 1970. $13.00.

This volume is an excellent, comprehensive review of the subject consisting of clearly defined chapters on basic anatomy, pathophysiology, physical signs and symptoms, surgical techniques and results.

The illustrations are extremely clear and pertinent to the printed material. It is of minor significance, but in most cases the illustrations are adjacent to the topics under discussion.

The general practitioner will be pleasantly surprised to find clear descriptions of daily encountered cerebrovascular diseases. The surgeon will find guidelines from surgical indications through operative technique to care of complications. This is a prodigious task for one book, but the authors have produced an unusually useful work that deserves a place in most medical libraries.

JACK B. CAMPBELL, M.D.

Synopsis of Dermatology, 2nd Edition. By William D. Stewart, M.D., Julius Danto, M.D., and Stuart Maddin, M.D. 445 pages with 193 illustrations. St. Louis: The C. V. Mosby Co., 1970. $13.85.

This synopsis presents a concise, clear introduction to dermatology. The division into four parts—structure and function, clinical examination and therapeutics, regional diagnosis, and specific skin diseases—is unique and very useful.

The brief discussion on primary skin lesions and pathological cutaneous processes is excellent and should prove invaluable to the student. The discussion on therapeutics and dermatological techniques is understandably short, and the reader should refer to other material for more detailed dermatological technique.

The photographs in general are excellent; however, photographs of urticaria, lichen planus, and pityriasis rosea, three of the most common skin diseases, could be improved upon.

The chapter on regional diagnosis presents the more common skin diseases in relation to the various regions of the body and should be of great value to the student.

This book gives one of the best discussions on drug eruptions available. All practicing physicians, as well as medical students, would indeed benefit by reading and studying this chapter.

Synopsis of Dermatology is an excellent introduction to the study of skin diseases.

J. M. BROCK, M.D.

Medicine Computer Diagnosis Developed

Mead Johnson Medical Services, Inc. has announced the introduction of Computer Assisted Diagnosis for internal medicine. Wayne A. Davidson, president, Mead Johnson Laboratories, made the announcement.

The C.A.D. systems for internal medicine and pediatrics apply computer technology as an assist to the physician in making his diagnosis.

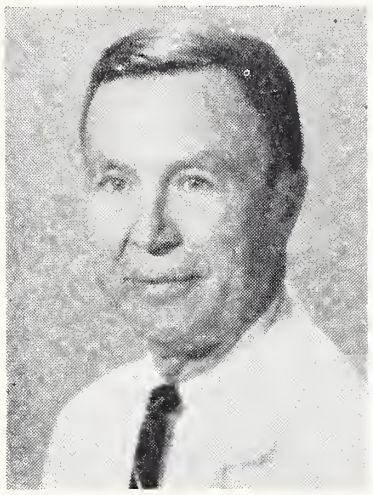
To use Computer Assisted Diagnosis, the computer is called by a teletypewriter installed in the doctor's office, at the hospital, or other central point. The physician or his assistant will then enter the findings into the computer by means of numbers which correspond with those listed beside particular findings in the operating manual.

The computer then compares these findings with those stored in its memory bank and responds with a printed listing of those diseases or syndromes which are found to be supported by the patient's findings. The computer will also provide a literature reference and additional findings which the physician should look for in determining the diagnosis.

One of the key advantages of C.A.D. is that it saves the physician's time. In making diagnoses, the physician must often conduct a time-consuming search of medical literature related to his findings after patient examination. Computer Assisted Diagnosis for internal medicine gives him ready access to diagnostic information screened from medical literature pertaining to the particular illness.

Dr. Blount Named Dean and Director

Dr. Robert E. Blount has been named director of the University Medical Center and dean of the medical school, according to University of Mississippi Chancellor Porter L. Fortune. The Board of Trustees, Institutions of Higher Learning, confirmed Dr. Blount's appointment to the dual post at the regular meeting in Jackson recently.



Dr. Blount

Dr. Blount succeeds Dr. Robert E. Carter, dean and director from 1967 to 1970. He came to the Medical Center as an assistant dean in 1968 when he chose to retire from the armed forces after a distinguished 35-year career in Army medicine. A major general, he was commanding officer at Fitzsimons Hospital in Denver at the time of his retirement.

In announcing Dr. Blount's appointment, Chancellor Fortune said, "He is highly qualified for his new post as director-dean. His education and experience have prepared him to assume leadership in all the Medical Center programs, teaching, research, and medical care." Chancellor Fortune commented further that, "As the son of Dr. E. N. Blount who was a south Mississippi country doctor for half a century, the new director is especially interested in training physicians for community medicine and family practice in the state."

Dr. Blount was born in Bassfield and graduated from Bassfield High School. He got his B.S. degree at Millsaps College and his M.D. degree from Tulane University.

During World War II, he commanded the 129th General Hospital in the European Theater, subsequently going to the Far East Command in Tokyo as chief medical consultant after refresher training in internal and tropical medicine.

He was the first physician to recognize the military significance of the long incubation period of the Korean strain of malaria and subsequently headed the Army research team on the most dangerous of the malarias when it became apparent that drug resistant strains were prevalent throughout southeast Asia.

In the 1950's, Dr. Blount was at Walter Reed and Brooke General Hospitals, served in Europe, in the office of the Surgeon General, and as senior internist to the Project Mercury Medical Specialty Team. He commanded the U. S. Army Medical Research and Development Command from 1962 to 1965, and William Beaumont General Hospital in El Paso, Texas, for one year before going to Fitzsimons.

Dr. Blount is a diplomate of the American Board of Internal Medicine, a fellow of the American College of Physicians, and has been on the medical school faculties at Baylor and the University of Colorado. He holds membership in numerous professional and scientific societies and is the author of some 25 publications.

Dr. Blount is a Methodist, member of the Downtown Kiwanis Club, and the Board of Directors of the Mississippi Heart Association. He is newly named to the Advisory Committee for an in depth study of medical and research development in the U. S. Army Medical Department in Vietnam and Southeast Asia.

Clay County Plans to Establish Kidney Unit

Dr. John D. Bower, director of the artificial kidney unit at the University Medical Center in Jackson, was guest speaker at the Clay County Kidney Foundation Benefit Banquet held recently at the Golden Triangle Center.

The banquet was sponsored by the West Point Breakfast Civitan Club and all proceeds went to the local kidney foundation.

Clay County citizens have now contributed several thousand dollars for a kidney machine to be placed in Ivy Memorial Hospital in West Point, according to local kidney foundation committee chairman Noel M. Wright, Jr.

Dr. Bower explained the operation and uses of the artificial kidney unit and discussed the unit at Jackson.

He pointed out that the proposed unit for West Point could aid eight patients and greatly reduce the cost of their having to make several weekly trips to Jackson and Memphis for dialysis.

The selection of patients would be handled in a central center outside the area, probably in Jackson. In order to be eligible to use the machine, the patient would have to be referred to the central center by his physician, said Dr. Bower.

New Sheraton-Biloxi Is Luxury Site of Association's 103rd Annual Session

Arrangements are virtually complete for the 103rd Annual Session in the just-opened luxury convention facility, the Sheraton-Biloxi. Meeting dates are May 3-6, 1971.

Located immediately east of the Broadwater Beach Hotel, the new Sheraton complex consists of a nine-story tower fronting on the Gulf with five connected two- and three-story lanai units on the north or back. There are 300 rooms and suites and 30,000 square feet of public space for meetings and exhibits.

All rooms and suites have balconies or patios, either on the Gulf or the interior hanging garden, cascade pools area. There is even an Astroturf putting green with nine holes. Room rates are competitive with other Gulf Coast convention and better motel facilities with single rooms from $15 and doubles from $20.

Approval for contracting use of the facility was given by the Board of Trustees after a survey committee had visited the new hotel. Annual session reservations with another major Coast facility were terminated by Board action.

The new Sheraton offers convention facilities



Air view of new Sheraton-Biloxi luxury convention hotel shows tower fronting on Gulf with five-unit lanai sections to north. Interior of complex has two cascade swimming pools, hanging gardens, Astroturf putting green, and walkways. All rooms and suites have balconies or patios.

including its Grand Ballroom with 8,000 square feet which may be partitioned with zero-decibel dividers to assure acoustical insulation. The Gulf Rooms, four in number, may be used separately or opened to a second large area 96 feet in length.

At the lobby level are two smaller meeting areas, the Biloxi and Boston rooms. There are semi-private lounge areas in the first and second level lobbies.

Food facilities include a second level all-day dining room, the Del Rosa, and a luxury supper club at the ninth level, the Top of the Sheraton. It may also be used for major meetings through the day.

Overflow rooms will be available in adjacent facilities, including a new Ramada Inn which is immediately east of the Sheraton, assuring adequate new and modern rooming accommodations for physicians, their families, and annual session guests.

Brochures and reservation request cards have been mailed to all association members, according to Dr. Raymond S. Martin, Jr., of Jackson, chairman of the Council on Scientific Assembly. He said that the hotel is confirming reservations now.

Schedule of the annual session calls for convening of the House of Delegates on Monday, May 3, at 9:00 o'clock in the morning. Afternoon activities will center around reference committee hearings.

The Scientific Assembly opens Tuesday morning with scientific and technical exhibits and the General Session on Obstetrics and Gynecology.

Tuesday afternoon highlight will be the General Session on Surgery. Wednesday will be devoted to medicine in the morning and preventive medicine and general practice in the afternoon.

Thursday rounds out the scientific program with pediatrics and EENT in the morning with the adjourned meeting of the House of Delegates set for the afternoon when final actions will be



Summer fun at night shows cascade pools and hanging gardens in interior of new Sheraton complex. North side of tower overlooks interior with balconies on each room. Upper tower level is luxury supper club, the Top of the Sheraton. View is from east lanai units.

taken on reports and resolutions and 1971-72 officers are elected.

Concurrent specialty society meetings are being arranged, Dr. Martin said, and most will coincide with scientific section days on relation of specialty activities.

The Council on Scientific Assembly said that the annual association dinner party has been deleted from the 1971 schedule in favor of an association-wide fellowship hour after which registrants may attend dinners of personal preference or enjoy the Coast restaurants. Attendance at the traditional Wednesday evening occasion has declined in recent years, prompting the new arrangement.

Other activities slated include the annual session of the Woman's Auxiliary which will meet concurrently in the Sheraton. The annual Fifty Year Club luncheon, honoring half-century M.D.'s, is scheduled.

Dr. Martin said that the seven scientific sections have organized top-flight programs with outstanding essayists and timely pertinent topics of wide professional interest.

Outside recreation will include the annual association golf tournament and water sports. The rapidly rebuilding Coast boasts a number of new restaurants and recreational facilities. In the immediate area of the Sheraton, rebuilding from the devastation of Hurricane Camille has been remarkable.

Members are encouraged to secure reservations early at hotels and motels of choice. Association spokesmen said that the complete program of the annual session will be published in the April JOURNAL.

Heart Center Dedicated at Jackson

Using gold suture scissors presented by the Mississippi State Medical Association, Dr. T. E. Wilson of Jackson, first MHA president, cut the ribbon, dedicated and officially opened Mississippi's new heart center at Jackson.

Other principals in the Mississippi Heart Association ceremony were Bishop Joseph B. Brunini, who gave the invocation; Miss Lucile Little, MHA executive director; Dr. Paul B. Brumby of Lexington, MSMA president; Dr. G. Spencer Barnes of Columbus, current MHA president; and Mr. Heber Ladner, 1971 MHA campaign chairman and secretary of state of Mississippi.

Dr. W. K. Purks of Vicksburg gave the keynote address. He recalled the heart association's earlier days, noted its progress, and especially emphasized its support of cardiovascular research at the University Medical Center.

Dr. Barnes presided over the ceremony and Mr. Ladner responded to the keynote address.

The new building is the headquarters for 16 staff members and the entire heart fund drive and program. Its special mission is information, one of three services the association renders. Service to the community and research complete the heart association's functions.



Dr. T. E. Wilson of Jackson, second from right, first MHA president, cut the ribbon and officially opened the Mississippi Heart Association's new headquarters building on McWillie Circle in Jackson. Also participating in the ceremony were, from left, Miss Lucile Little, MHA executive director, Dr. Paul B. Brumby of Lexington, Mississippi State Medical Association president, and Dr. G. Spencer Barnes of Columbus, current heart association president.

Besides office space, the center contains a multi-purpose room with audiovisual facilities for workshops, demonstrations and committee meetings; mail, reproduction, storage, reading and exhibit rooms.

The one-story building is constructed of brick exterior and painted concrete block interior walls. The lot on McWillie Circle was purchased with a bequest from the estate of Mrs. Ethel Ketcham of Jackson and reserve funds completed the financing cost, according to Miss Little.

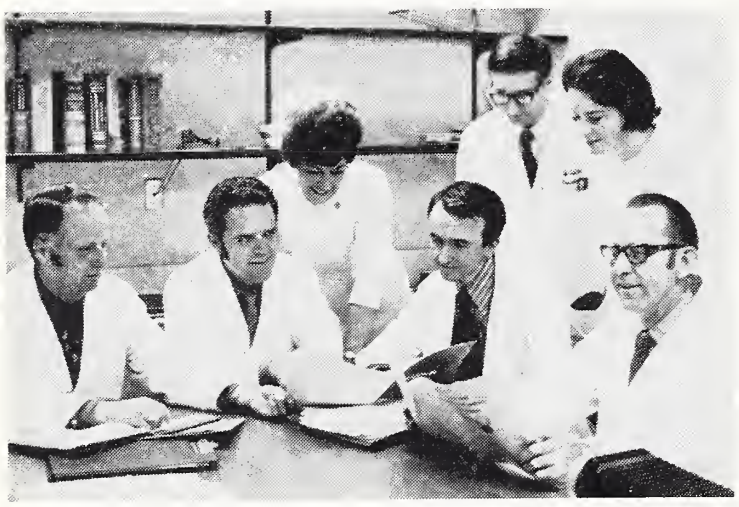
Drs. Smith and Lockey Join UMC Faculty

Dr. George V. Smith and Dr. Myron W. Lockey have joined the full-time teaching staff at the University of Mississippi School of Medicine.

Dr. Smith, surgery associate professor, is a native Mississippian who earned the B.S. degree at the University of Mississippi and the M.D. from Harvard Medical School. He interned at Charity Hospital, New Orleans, and did his residency at Hartford Hospital in Connecticut. Formerly director of the Jackson County Health Department in Pascagoula, Dr. Smith was an assistant professor of surgery at the University of Connecticut immediately prior to his Mississippi appointment.

Dr. Lockey, clinical assistant professor of surgery (otolaryngology) since 1966, is now a full-time assistant professor in that department. A Mississippi medical school graduate, he interned at the Medical Center in Jackson and took his residency at the Veterans Administration Hospital in Dallas, Texas.

Four Attend PG Institute Course



A class of four attended the year's second session of the Mississippi Postgraduate Institute in the Medical Sciences stroke intensive course at the University Medical Center in January. Participants were, seated from left, Dr. James M. Dabbs of Waynesboro, Dr. L. H. Brandon of Starkville, Dr. John M. Estess of Hollandale and Dr. Gordon S. McHenry of Wiggins. Reviewing stroke material with the physicians are, standing from left, Mrs. Irma Trask, Mississippi Regional Medical Program stroke unit head nurse, Dr. Ancel C. Tipton, medicine instructor and electroencephalography director, and Mrs. Mary Ware, stroke unit nurse. MRMP supports the Institute.

Synthetic, Absorbable Suture Introduced

The first synthetic and absorbable suture, said to approach the ideal in suture material by offering a combination of qualities never before available to the surgeon, is currently being introduced in the United States by Davis & Geck, a unit of American Cyanamid Company.

Approved by the Food and Drug Administration in Nov., 1970, the DEXON® polyglycolic acid suture, synthetic, absorbable, sterile braided, is medically significant in that it provides exceptional handling characteristics with the flexibility of silk, tensile strength superior to all non-metallic sutures, excellent fray resistance as compared to catgut and consistent knot security. Furthermore, it causes little or no tissue reaction compared to other suture material. DEXON represents the culmination of a nine-year research and development effort by Cyanamid's worldwide research facilities.

DEXON has already received wide acceptance by surgeons in the United Kingdom where it was introduced in July, 1970.

U. S. distribution will begin immediately. DEXON may be used in place of both absorbable and non-absorbable sutures in most surgical procedures. It is the first absorbable suture ever made from a laboratory-engineered polymer especially designed to meet the specific requirements of surgeons.

Studies of absorption capabilities show that DEXON is more compatible with tissue than absorbable sutures made of animal gut or collagen.

Dr. William M. Sweeney, director of Medical Research of Lederle and Davis & Geck, said, "The virtual absence of reaction during wound healing may be due to the fact that DEXON contains no protein and is apparently absorbed by simple hydrolysis while catgut and regenerated collagen —both proteinaceous—are absorbed by proteolysis. It is believed that this difference accounts for lessened edema and irritation, thus reducing discomfort in some procedures and contributing to more rapid convalescence."

Before release to the surgical profession, DEXON was tested successfully in more than 5,000 operative procedures by surgeons around the world. Dr. Sweeney states, "The results indicate DEXON may very well be the ideal replacement for existing absorbable and non-absorbable sutures in most surgical procedures."

State M.D.'s Participate in Thoracic Conference



Members of the Mississippi Thoracic Society participating on the program at the 15th annual Tri-State Thoracic Society Case Conference at the Buena Vista Hotel in Biloxi, are, standing from left: Drs. Boyd Shaw and Karl Stauss, both of Jackson; Dr. Dwight Keady, Sanatorium; seated from left: Dr. Guy Campbell of Jackson, Dr. Averial Liebow of La Jolla, Calif., guest speaker, and Dr. Daniel T. Keel of Brookhaven. This scientific conference on respiratory diseases is a part of the medical education program of the Mississippi Tuberculosis and Respiratory Disease Association and is financed with Christmas Seal dollars. Alabama and Louisiana TB-RD Associations and Thoracic Societies jointly sponsor this conference with the Mississippi group.

Baptist Hospital Holds Merchandise Fair

Products of interest to physicians and hospital personnel will be on display at Mississippi Baptist Hospital March 25-26 at a "Merchandise Fair" scheduled for those dates.

The event was announced by Mrs. Dorothy Crow, R.N., the hospital's director of in-service training, and by Mrs. Winnie Curcio, the hospital's central supply supervisor.

"Some 500 people attended our last display," said Mrs. Crow, "and we believe that there will be even more on hand this time, to view the many things used in a hospital."

The purpose, she said, is to acquaint doctors and hospital personnel with new equipment and with the advantages of their use, and to reacquaint them with existing equipment.

She said the equipment includes syringes, abdominal bindings, dressings, solutions, bed pans, the newest drugs, stockings for surgery patients, and many other items.

The show will be held on the third floor of the hospital's Lackey Building from 7 a.m. to 4:30 p.m. both days. The early opening hour is for the benefit of those going off night duty.

Vicksburg M.D.'s Speak on Drug Abuse

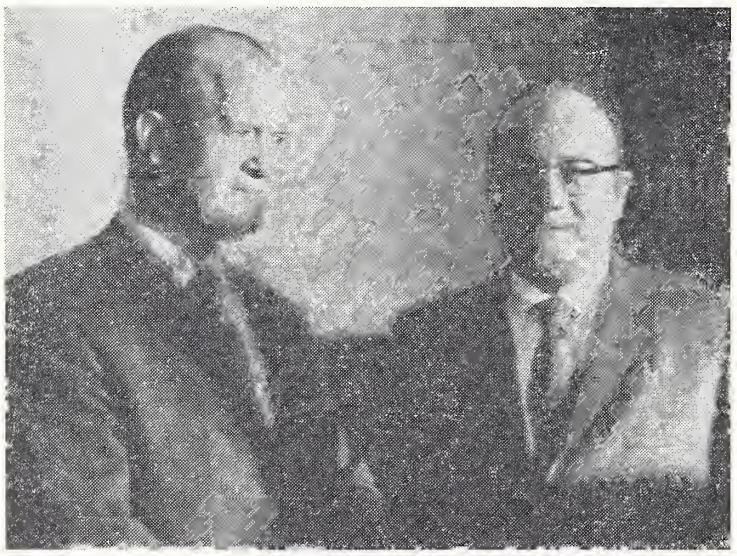
Six physicians took active roles in a drug abuse education program sponsored by the Vicksburg Junior Auxiliary, Kiwanis Club, police department and the United Fund.

Speakers went to city and county schools during the designated week in January.

Primary purposes of the program are two-fold: (1) to give all known facts and aspects of drug use and abuse fairly and to attempt to stimulate the student to play the role of the final arbiter, to do so intelligently and with a sense of responsibility for his own well being; (2) to encourage communication on the subject of drugs between generations.

Participating physicians included Drs. Jerry Ross of Whitfield, Karl W. Hatten, S. Kimble Love, Clark Williams, Charles Marascalco, and Joe M. Ross of Vicksburg. Other speakers were educators, attorneys and policemen.

Association Testifies on Abortion Amendments



Dr. James L. Royals of Jackson, right, immediate past president of the Mississippi State Medical Association and a gynecologist, testified on behalf of the association against the abortion on-demand amendment recently defeated in the Mississippi legislature. After the hearing, Dr. Royals chatted with Rep. William A. Tisdale of Biloxi, the only physician member of the legislature and the sponsor of the association's bill to amend the abortion laws.

Whitfield Has Work Rehab Program

The therapeutic value of work is being illustrated in a comprehensive rehabilitation program which has been in effect at the Mississippi State Hospital at Whitfield for the past two years.

The program coordinator, Dr. H. R. Nail, the institution's director of rehabilitation services, describes it as "an active treatment program to help chronic patients reach the highest level of which they are capable." Dr. Nail points out that this does not necessarily mean that all patients can be returned to an active community role. They may remain at Whitfield. But they will be active at Whitfield and not passive recipients of custodial care. Chronic patients represent the largest segment of the hospital's population, Dr. Nail points out.

In the past, the occupational-therapy facilities of the hospital were used by about 50 patients a day who were self-motivated. Today, some 500 patients attend occupational-therapy sessions daily.

The difference is in the concept of "prescription therapy," a concept established as the keystone of rehabilitation, in which Whitfield's psychiatrists and other physicians prescribe therapy for those patients they feel can best benefit thereby. Thus, occupational therapy becomes a part of prescribed treatment and not something the patient can take or ignore, as he chooses.

The occupational therapy is only part of the total rehabilitation programs at Whitfield, which consists also of recreational therapy (with each unit at the hospital participating), the library, the many and varied volunteer services (including all kinds of self-help activities, sessions on personal hygiene, parties, bingo games, etc.), and an Allied Enterprises vocational workshop program under the Division of Vocational Rehabilitation of the State Department of Education which has resulted in some marked improvements in patients.

But while it is only a part of the total picture, the prescribed occupational therapy is the crux of the program, because here is where a completely non-motivated patient is encouraged to look at the world outside of his own thoughts and anxieties and engage in some worthwhile activities. As a result, some of these patients begin the upward road to progress and are ultimately returned home, but Dr. Nail emphasizes that this is not the only goal. The program also rewards chronic patients with meaningful accomplishments within the hospital setting.

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n alternative o conventional therapy

Efudex (fluorouracil) offers the physician a ical alternative to cryosurgery, electrodesiccation d cold-knife surgery in the treatment of solar/actinic atoses. It is effective, comparatively inexpensive and ecially well suited for treatment of these multiple ions. Important, too, is the highly desirable cosmetic ult. Clinical experience demonstrates that treatment h Efudex results in an extremely low incidence of rring.*

lighly effective

In clinical trials, depending on the dosage form d strength used, complete involution occurred in to 88 per cent of lesions following treatment. The e of recurrence was low, ranging from 1.7 to 5.6 per t up to a year after completion of therapy. When w lesions appeared, repeated courses of Efudex rapy proved effective.*

redictable nerapeutic response

Two to four weeks constitutes a typical course Efudex therapy. The response is usually characteris- and predictable. After three or four days of treat- nt, erythema begins to appear in the area of keratoses. is is followed by an intense inflammatory response, ling and occasionally moderate tenderness or pain. e height of the inflammatory reaction generally occurs o weeks after the start of therapy, and then begins subside as treatment is stopped. Within two weeks of continuing medication, the inflammation is usually ne. A mild erythema may remain for two or three nths before gradually receding. Since this response o predictable, lesions which do not respond ould be biopsied.

wo strengths—two osage forms

Efudex is available as a 2% or 5% solution or a 5% cream. It is applied twice daily by the patient th a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, two im- rtant considerations: First, please consult the com- te prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing-cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



new
Efudex®
(fluorouracil)
cream/solution

ata on file, Hoffmann - La Roche Inc., Nutley, New Jersey.

Dr. Guess Appointed Pharmacy School Head

Chancellor Porter L. Fortune, Jr., has announced the appointment of a prominent Texas educator and researcher as Dean of the University of Mississippi's top-ranked School of Pharmacy.

Chancellor Fortune said Dr. Wallace L. Guess, professor of pharmacy and director of a highly regarded drug and toxicology research laboratory at the University of Texas at Austin, will become Dean of the Ole Miss School of Pharmacy effective July 1.

"Dr. Guess has distinguished himself both as a superior teacher and as an outstanding researcher. Coming to the University from the position of Director of the Drug Plastic Research and Toxicology Laboratories at the University of Texas College of Pharmacy, he is especially well qualified to fill the position of Dean of our School of Pharmacy with its extensive programs providing leadership in pharmaceutical education and research," Chancellor Fortune said.

Dr. Guess, 46, fills the position left vacant by the accidental death last April of Dean Charles W. Hartman.

Originally from Durham, N. C., Dr. Guess has served since 1967 as Director of the University of Texas' Drug Plastic Research Toxicology Laboratories, a unique research facility financed by governmental agencies and industry. Research conducted at the laboratory has resulted in nearly 100 scientific papers presented before various scientific disciplines.

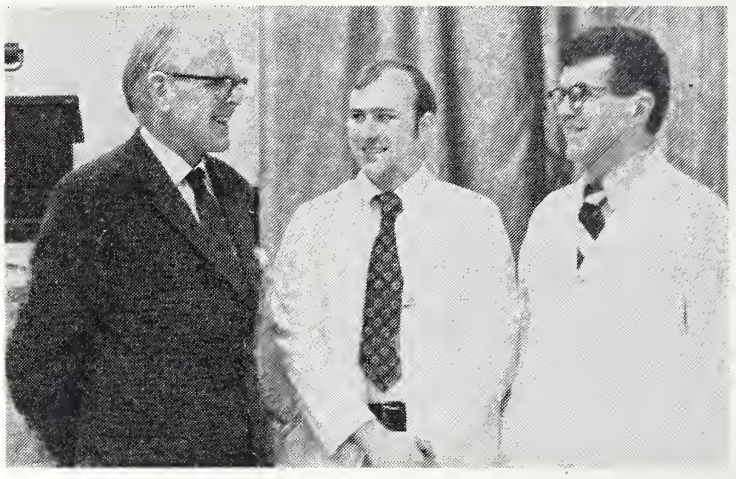
Dr. Guess earned his undergraduate degree in 1949 and his master's degree in 1951, both at the University of Texas. He was awarded the Ph.D. degree in pharmacy from the University of Washington in 1959.

In the summer of 1962, Dr. Guess did postdoctoral work at the State Toxicology Laboratory at the University of Washington, and also in 1964 at the Department of Pathology at the Harvard Medical School. In 1965 he was an invited scientist at Ciba Pharmaceutical Company Toxicology Department.

The author of 55 professional papers, Dr. Guess is the recipient of a Lederle Award Research Paper and has been named a Fellow of the American Foundation of Pharmaceutical Education. He has held consulting positions with the Texas Nuclear Corporation, Alcon Laboratories and Edwards Laboratories, Inc., and has received research grants from government agencies and industries, including Ciba Pharmaceutical Corporation, University Research Institute and the National Institutes of Health.

Dr. Guess holds membership in the American Pharmaceutical Association, Academy of Pharmaceutical Sciences, Kappa Psi, American Association of Colleges of Pharmacy and Society of Toxicology, Sigma Xi and Rho Chi, professional and honorary organizations.

UMC Hosts Two Distinguished Speakers



Dr. Denis P. Burkitt, left, and Dr. William H. Crosby, right, were visiting lecturers at the University of Mississippi Medical Center in January. Dr. Burkitt, the British physician who first defined Burkitt's lymphoma, a jaw tumor found in Central African children, reported his latest research findings. Dr. Crosby, Tufts University medicine professor and director of the Blood Research Laboratory at New England Medical Center, was a UMC visiting professor of medicine. Talking with the visitors is Don Blackwood of Drew, center, president of the medical student body.

Blood Bank Association Meeting Set

The South Central Association of Blood Banks has scheduled its 13th annual meeting for March 17-19 at the Arlington Hotel in Hot Springs, Ark.

A preconvention session on March 17 will include an administrative and technical workshop. Other conference highlights will include panel discussions and exhibits.

A variety of speakers will cover such topics as the Australia Antigen and hepatitis, oxygen-hemoglobin dissociation in stored blood, and customized emergency transfusion for the neonate.

Urokinase Proved to Be Effective

The clot-dissolving agent urokinase plus anticoagulants outperformed anticoagulants alone in relieving pulmonary blood-vessel obstruction and improving bloodflow to the lungs in patients with pulmonary embolism, according to results of the recently completed Urokinase Pulmonary Embolism Clinical Trial.

The study, the first published controlled clinical study of the clot-dissolving capacity of any fibrinolytic agent, was carried out by the National Heart and Lung Institute through contracts awarded by its National Blood Resource Program. It involved a total of 160 patients in 16 co-operating institutions. The study results were reported in the Dec. 21, 1970 issue of the *Journal of the American Medical Association.*

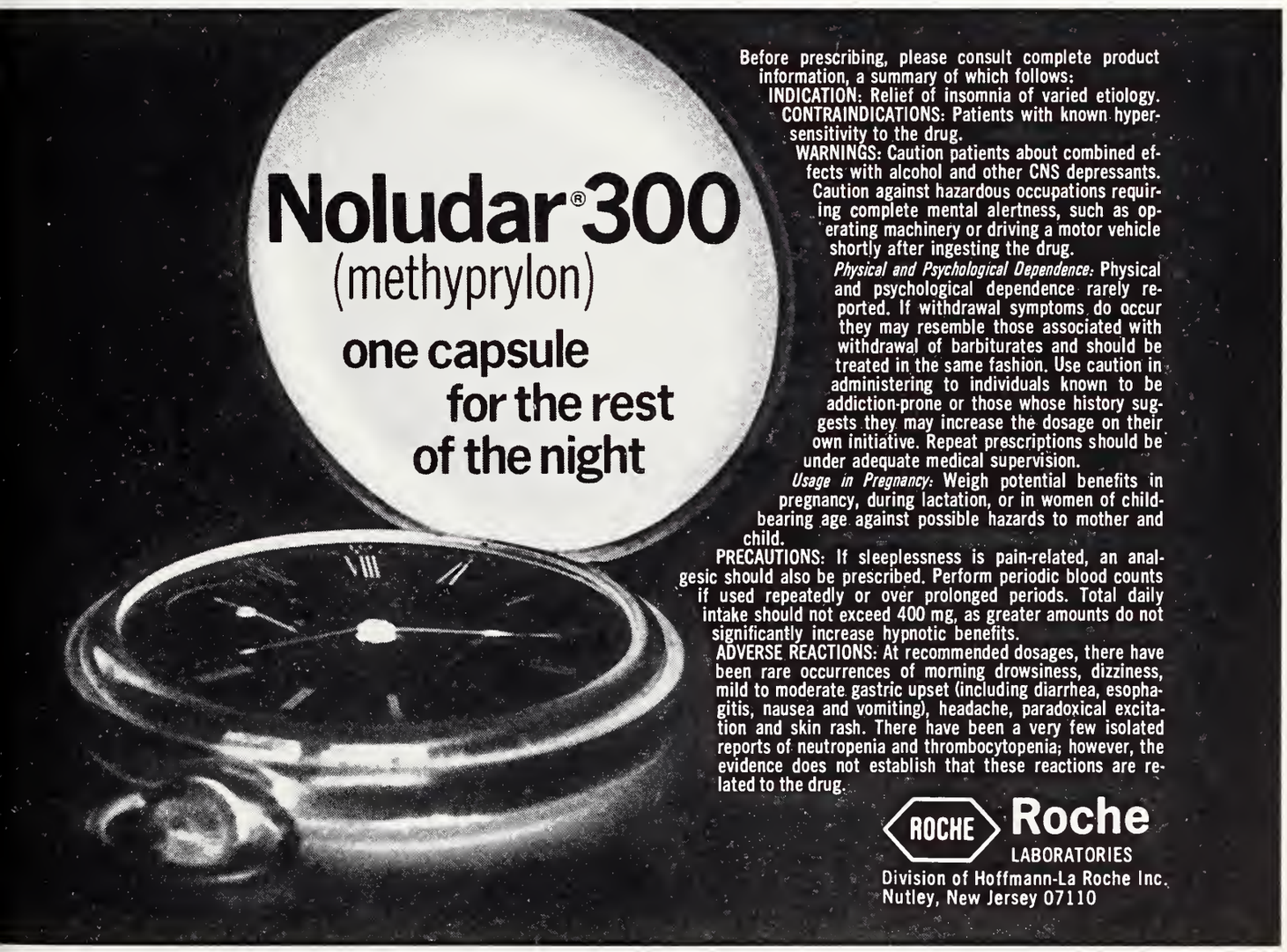
Of the 160 patients, 82 received 12-hour urokinase infusions followed by intravenous heparin for at least five days. The 78 controls received only intravenous heparin for a like period. Thereafter, both groups were maintained on oral anticoagulants.

There was a high rate of clinical improvement in both groups; but objective evidence of improvement, on the basis of X-ray visualization of the pulmonary blood vessels after 24 hours, was more pronounced in the urokinase-treated group than in the controls. Judged on this basis: Distinct improvement was observed in 30 urokinase-treated patients, but in only five control patients. Urokinase-treated patients with larger clots at the beginning of therapy usually showed the most marked improvement, a tendency not observed in the control group.

The extent of clot dissolution and improvement in lung perfusion, as judged from radioisotopic lung scans, was greater in the urokinase-treated group than in the control group during the first 24 hours. Thereafter, however, the between-group differences diminished steadily and, by the fifth day, had all but vanished.

Improvement in various indices of heart performance was substantially greater in the urokinase-treated group during the first 24 hours.

Bleeding complications during therapy were more common and were more often severe among urokinase-treated patients. Severe bleeding, characterized by a significant fall in red-cell concentration and sometimes requiring transfusions, occurred in 22 urokinase-treated patients versus 11 control patients.



FDA Approves Lilly's Keflex®

The Food and Drug Administration has approved Eli Lilly and Company's new drug application for Keflex® (cephalexin monohydrate, Lilly), a major addition to the company's antibiotic product lines in the United States.

Keflex is an oral form of the cephalosporin family of antibiotics developed by Lilly scientists. It was first introduced in August, 1969, in Hong Kong, and later in Spain, the United Kingdom, Mexico, France, and Japan.

It is planned to introduce the product in the United States during this quarter.

SBH Reports on VD in Mississippi

"Mississippi experienced a slight reduction in infectious syphilis last year, but gonorrhea morbidity is out of control and getting worse," said Dr. Durward Blakey, Preventable Disease Control Director for the State Board of Health, in reviewing last year's VD picture.

An 8.3 per cent decrease in primary and secondary syphilis was reported in 1970 over 1969.

However, Dr. Blakey noted that several counties reported significant increases. They included Clay, Copiah, Lee, Marion, Monroe, Quitman, Tippah and Washington.

In contrast to the statewide syphilis reduction, gonorrhea morbidity is soaring, with a 21 per cent increase reported in 1970, the public health specialist stated.

Morbidity reporting, according to Dr. Blakey, is always low—and especially with what he terms "stigma-attached diseases" such as syphilis and gonorrhea.

"Venereal diseases among young people continue to be a serious problem in Mississippi," Dr. Blakey stated.

Young people under 25 years of age accounted for 74.4 per cent of all gonorrhea cases that were reported in the state in 1970, he pointed out.

In the under-20 age group were 35.8 per cent of the gonorrhea cases.

As to infectious syphilis, the PDC director said that 56 per cent of all cases last year were under 25 years of age, and 26 per cent were under age 20.

"We anticipate that the bill, just passed by the Senate and House, that provides for treatment to minors without parental consent, will undoubtedly do a great deal to improve investigating and treating of these two major diseases that are rampant among our young people," Dr. Blakey stated.

Premature Lifeguard Developed

A "lifeguard" that protects premature babies has been developed by British engineers of International Telephone and Telegraph Corporation.



Lifeguard for premature babies, signals immediately if the baby stops breathing, a not-uncommon ailment of such infants. The mattress, developed by British engineers of International Telephone and Telegraph Corporation, monitors the slight motions of the child's body as it breathes. It flashes a signal if the baby's breathing ceases due to the ailment called apnoea.

ITT's subsidiary Standard Telephones and Cables Ltd. of London, England, reported the device protects the infants from an ailment known as apnoea, a condition in which the baby suddenly stops breathing for no apparent reason.

STC's engineers developed a special mattress to detect this condition. The baby merely lies on this special mattress; this has the advantage that nothing is connected to the child.

The mattress has a number of tubular sections filled with air. When the baby breathes, the small motions of its body cause the air to circulate around a pinhead-sized electrical device (a "thermistor"), which is cooled by the moving air. Should the baby stop breathing, the air stops circulating, the device immediately warms up, and an alarm sounds.

The concept is advantageous especially in times of hospital help shortage.

ACOG Schedules Clinical Meeting

The nineteenth annual clinical meeting of the American College of Obstetricians and Gynecologists will be held May 3-6 in San Francisco.

The program will develop three themes, perinatology, pelvic infections, and diseases of the vulva, in general sessions, correlated seminars, round tables and reports on clinical investigations.

Non-Fellows may register to attend the meeting and the postgraduate courses which will precede the meeting on May 1-2.

For further information, contact Donald F. Richardson, 79 West Monroe Street, Chicago, Illinois 60603.

1971 Miss. Arts Festival Set

Sensational—in every sense of the word—describes the atmosphere that will come alive when the eighth annual Mississippi Arts Festival opens April 25 in Jackson. In addition to the spectacular sights and sounds provided by luminaries of the entertainment world nightly in the Coliseum, a variety of experiences await festival goers throughout the exhibition halls and—for the first time—on the midway.

Once simply a parking area, the midway this year will be a focal point of the eight-day spring celebration of the arts. In the center, a free-form exposition will invite visitors to experience exaggerated effects of the sensory aspects of our environment. Creative use of light, wind, sound, scent and water will propel participants through the sensory gamut.

Another 1971 innovation will be the charming and colorful Pavillion Restaurant, an open-air dining spot where a full, varied menu promises to appease the most discriminating tastes. Nearby, visitors may watch sculptors in motion. A portable foundry constructed especially for the festival will be in continuous use as aluminum and bronze creations are cast.

Headliners for America's only state-wide arts festival, who perform each evening in the 10,000-seat Coliseum and Jackson's handsome new city auditorium, will be announced shortly.

Along with these internationally-known guest artists, top-notch musicians, vocalists, writers and actors from throughout the South will exhibit their skills in Pavillion attractions along the midway, with plays, concerts and coffee house entertainment featured nightly.

Artists of every age and talent—from preschoolers to pros—will be exhibited on the Festival grounds. The highly acclaimed "Images on Paper," a select showing of national prize-winning artists, will lead the exhibition agenda. Mississippi's finest native artists will display their for-sale works in the "Little Gallery," an exclusive spot planned along the Festival midway. The popular Clothes-Line showing sponsored by the Mississippi Art Enthusiasts will again be seen. Completing the exhibition line-up will be a showing by area high school artists, and winners of the statewide children's art competition, sponsored each year by Junior Auxiliaries throughout Mississippi.

The Children's Division this year will also seek to involve all the senses, with an experience planned in which each letter of the ABC's will represent a delightful sensory happening for the youngsters. Some 10,000 young people are expected to hear the dynamic Jackson Symphony Orchestra in three concerts especially planned for them during the Festival week. A fourth concert —A Symphony Sampler—open to everyone will be presented in the Coliseum on Saturday.

Prominent Southern writers and dramatists have been engaged to judge the Mississippi Arts Festival's 1971 literary competition. Opened to native or resident Mississippians, the contest includes the categories of short story, formal essay, informal essay, poetry and drama. Competition is divided into junior (high school students) and senior (college students and adults) sections. The Mississippi Authority for Educational Television has reserved the right to adapt any winning entries for television.

All-inclusive ticket packets—priced at $5, $10 and $15—are on sale by mail. Information may be had by writing MAF Tickets, P.O. Box 4354, Jackson, Miss. 39216. Each packet includes two evenings of major entertainment in the Coliseum and one evening in the city auditorium, plus the exciting array of attractions along the Festival midway.

For the first time in the Mississippi Arts Festival's history, the festival grounds will be opened to non-ticket holders, with minimal charges set for certain midway attractions.

The 1971 festival is being presented by the Mississippi Arts Festival, Inc., with Mrs. Davenport Mosby, Jr., serving as chairman of the production committee. Assisting are Mrs. Woodson Cowan, co-chairman; Mrs. Calvin L. Wells, treasurer; Mrs. Richard L. Yelverton, secretary; Mrs. Tim Jones, promotion; and Mrs. William D. Morrison, Jr., program advisor.

Counsel to Authors

The JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten doubled spaced on 8½ by 11-inch white bond paper with a standard typewriter.

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IN CONCLUSION

House Ways and Means Committee went into executive session Feb. 2 to write 1971 Social Security Amendments, including expected alterations in Medicare and Medicaid. Last witness was HEW Secretary Elliot L. Richardson who plugged Nixon welfare reform, actually increasing expenditures. Secretary Richardson also supported group practice and said that he did not want state medical associations to operate peer review in every instance.

American Academy of Orthopaedic Surgeons has published new 320-page text for training emergency medical technicians. Entitled "Emergency Care and Transportation of the Sick and Injured," the book details practical application of emergency care and rescue techniques. Topics in 58 chapters cover fractures, burns, poisonings, heart attacks, strokes, explosions, records, emergency vehicles, and legal responsibilities.

Particulate air pollution and cirrhosis mortality were causally associated by two California researchers. Working in Erie County, N.Y., two years, they classified population into five economic levels and air into four pollutant levels, permitting comparison of mortality among fixed economic groups but at differing levels of air pollution. Association was dramatic for $6,000 per year worker with mortality up 400 per cent in two years as air pollution increased.

American Academy of Pediatrics has published policy supporting concept that every American child has the right to high quality, comprehensive health care regardless of social status, area of residence or economic position. Calling for development of a national health plan for children, AAP concluded that "improving the health of children and youth is a corridor to better health for the entire population." Policy was released last month in AAP Newsletter.

Congress will doubtless wipe out third level of Medicaid, that of care for those age 21 to 64 who cannot qualify for welfare, in current session. This is the portion of program for which no federal money is provided and was most hotly debated aspect of law when Legislature enacted Mississippi program at 11th hour in 1969. Most states have already limited Medicaid to welfare recipients and near-needy, but Mississippi program is for statutory indigents only.

Volume XII
Number 4
April 1971

JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $7.50 per annum; $1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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NEWSLETTER

April 1971

ear Doctor:

en. James O. Eastland has introduced legislation aimed at re-
ieving shortages of physicians in rural areas. Bill provides
or payment in full by government for medical or dental education
th contingent obligation for three years practice in "deprived"
rea. Sen. Eastland said main objective is to furnish incentive
r more medical students to enter family practice in rural areas.

> Bill is in close policy alignment with state medical association position adopted at 102nd Annual Session. It is the second measure in Congress in four months to improve medical manpower outside cities. Other is act to assign public health physicians to rural areas.

n Landers, who describes herself as a human relations columnist,
s blasted chiropractors as cultists following unscientific dogma.
e popular writer with an estimated daily newspaper audience of
million cited cold facts, figures, and studies in denouncing
e spine punchers. Importance is Mrs. Landers' high credibility
th women who make most health decisions for their families.

reign medical graduates without the ECFMG certification cannot
ter AMA-approved residency programs. This was recent edict of
A Council on Medical Education which threatened accreditation of
aching hospitals violating decision. Ruling poses few problems
South, but northern metropolitan areas with majority of FMG's
house staffs could be in trouble.

estigious and influential Chamber of Commerce of United States
ll conduct referendum among members on national health programs.
llots will be mailed in a week and must be returned by April 24.
bjects to be covered include health care manpower, financing,
livery system, and peer review. Chamber has conducted year-long
alth care study, and referendum results will crystallize policy.

survey questionnaire is on the way to one out of eight association
mbers from Mississippi State University. Study is being made of
spital trustees, their duties, responsibilities, and performance
Roy E. Carpenter in research for doctoral dissertation. Work
timely in view of association's policy of having physicians as
ting hospital trustees. Answer promptly if you are in sample.

Sincerely,

Rowland B. Kennedy
Executive Secretary

Eight Appointed to Medicare Council

Elliot L. Richardson, Secretary of Health, Education, and Welfare, has named eight new members to the Medicare Advisory Council.

The 19-member Health Insurance Benefits Advisory Council is composed of physicians and lay experts in the fields of medicine and health care financing, as well as representatives of business, labor, consumer interests, and the general public. The Council reviews the operations of the Medicare program and makes recommendations for legislative and administrative changes.

The new members appointed to the Council are: G. Robert Cotton, president and chief administrative officer of the Cedar Knoll Rest Home, Inc., Grass Lake, Mich., and chairman of the Education, Research and Education Committees, of the American Nursing Home Association; Dr. James R. Cowan, New Jersey State Commissioner of Health; Oscar E. Gutierrez, D.O., director, Davila Medical Center, San Antonio; Edwin H. May, Jr., president of the insurance firm of May, Potter, and Murphy, Inc., Hartford, Conn.; William S. McNary, former executive director of the Greater Detroit Area Hospital Council, and president, from 1962-69, of the Michigan Blue Cross Plan; Dr. Jay S. Reibel, resident in psychiatry at Mt. Sinai Hospital, New York City, and former assistant director (1969-70) of Government Affairs of the American Medical Association; Dr. Ernest W. Saward, associate dean, University of Rochester School of Medicine and Dentistry, and president of the Group Health Association of America; and Dr. Harlan Thomas, in the general practice of medicine in Tulsa, and member of the American Academy of General Practice and of the House of Delegates, American Medical Association.

Full term appointments to the Health Insurance Benefits Advisory Council are for periods of four years. Five of the eight new members are being appointed to full terms; three are being appointed to fill out the terms of members who have resigned.

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DATELINE

's Medicredit Major Contender

Washington - Congressional cloakrooms are buzzing over popularity of AMA's Medicredit measure which has 125 plus sponsors. Capitol Hill insiders are saying that 92nd Congress would prefer it 3-to-1 over abd $77 billion Kennedy bill. Medicredit is close to Nixon bill, king only HMO feature. Separate bill on peer review will be induced soon. Medicredit sponsors from Mississippi include Sen. tland and Reps. Abernethy, Griffin, and Montgomery.

---

ldog Grads Plan ical Alumni Body

State College - Mississippi State University is organizing a medical affiliate of its alumni association, according to Dr. John C. Longest and rles Weatherly, general alumni secretary. Long respected for its ellent premed education program, MSU has many M.D. grads who can e up large and active alumni group. Recent organizational meet- has accelerated interest already shown in Mitchell Lectures and lden Spike" program.

Climbs on Bandwagon

Chicago - The American Hospital Association has endorsed principle of Health Maintenance Organizations (HMO) in some pending national health urance bills as Congressional and popular interest in its Ameri- n continues to drop. Heart of AHA proposal in Ameriplan is local alth care corporations" which, obviously, would be Blue Cross ns. AHA endorsement cited many problems in HMO's, saying that health care corporations offer solutions to all such problems.

York Abortion s Gets Worse

New York - Unchecked commercialism in abortions has made smelly situation in Empire State worse as frequency of procedure is now at 500,000 per r. State medical society is urging cutback in sky-blue law, and estigations are underway by executive agencies and legislative mittees. In sharp contrast, states with updated laws permitting cedure for medical reasons, such as unsuccessfully sought in Missippi, are experiencing no such problems.

-ERF Gifts line in 1970

Chicago - Physicians gave less and the Woman's Auxiliary gave more, but AMA-ERF receipts declined in 1970. Preliminary figures from year w that M.D. contributions dropped to $516,000 from $640,000 in 9, while Auxiliary gifts went up to $495,000 from $466,000. But al for 1970 was $1.1 million, down from $1.64 million in 1969. er gifts came from state association treasury grants and some industries. State-by-state figures will soon be released.

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References: 1. Lechevalier, H.: Antibiotics Annual 1959-196 New York, Antibiotica Inc., 1960. pp. 614-618. 2. Olsen, J.R Journal-Lancet *85*:287 (July) 1965. 3. Giorlando, S.W., Torre J.F., and Muscillo, G.: Am. J. Obst. & Gynec. *90*:370 (Oct. 1 1964. 4. Friedel, H.J.: Maryland M.J., *15*:36 (Feb.) 1966. 5. Gio lando, S.W.: to be published 1971. 6. Decker, A.: Case Report on File, Medical Department, Julius Schmid.

ey can now be cured with **Candeptin.** Even these two.





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FDA Sets Combination Drug Restrictions

The Food and Drug Administration has acted to insure that drugs composed of more than one ingredient combined in fixed dosage form (a pill, capsule, teaspoonful), are used only when such preparations offer the patient a therapeutic advantage over any one or more of the components administered separately.

The new policy affects up to 40 per cent of the most widely used prescription drugs and most over-the-counter drugs.

In announcing a formal declaration of proposed policy, FDA Commissioner Charles C. Edwards, M.D., said, "FDA fully recognizes that some combinations have a legitimate place in medical practice. Our purpose is to insure that fixed combination drugs not only are safe and effective but are formulated so they can be used rationally and in dosages matching concurrent therapy needs of the patient."

As a result of FDA's drug efficacy study and implementation program (DESI), the agency has taken a number of actions which make clear its attitude toward combination drugs. Some combinations already have been declared ineffective on the basis of DESI.

In addition to formalizing currently effective policy, the proposal is expected to provide useful guidance to industry in considering the introduction of future combination products. The policy proposal sets several criteria for new drugs coming to the marketplace as combinations and for old combination drugs remaining on the market. FDA would approve combinations where there is proof that each active ingredient contributes to the effects claimed for the fixed combinations.

Each added ingredient would have to enhance: effectiveness of the drug by increasing potency or prolonging its effects; safety of the drug by decreasing or reducing severity of adverse effects, or prevent possible misuse or abuse. When two or more drug components are given, instead of one, the advantages of the combinations would have to apply for schedules and durations of use recommended.

"FDA has found combination drugs present a unique problem," said Dr. Edwards. "They sometime have advantages for the patient of convenience, economy, and better adherence to medication-taking schedules."

Interested persons may comment to the hearing clerk, Department of Health, Education and Welfare, Room 6-62, 5600 Fishers Lane, Rockville, Md. 20852.

Brief Summary of Prescribing Information– 9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
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April 1971, Vol. XII, No. 4

ORIGINAL PAPERS

Ambiguous Genitalia in the Newborn

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Jackson, Mississippi

A brief review of the normal processes of sexual differentiation and the application of this knowledge to the work up and differential diagnosis of the infant with abnormal or ambiguous genitalia is presented in this eighth paper of the Seminar on Care of the Newborn series. The author discusses the three basic diagnostic procedures for sex assignment: complete history, buccal smear, and determination of urinary levels of 17 ketosteroids. He also points out the importance of explaining to the parents that their child's problem is a birth defect and that the decision to be made for their baby is the only possible correct one.

THE ASSIGNMENT OF SEX to a newborn infant without a careful examination of the external genitalia can lead to erroneous sex assignment in infants with ambiguous or abnormal genitalia. To avoid the psychological trauma and the multitude of problems that such an error can bring about, sex should not be assigned in any infants with abnormal external genitalia until the physician has completed certain essential diagnostic procedures. Selection of the appropriate sex of rearing will depend on the etiology of the abnormality, the anatomy of the sex organs, and the degree of correction that can be expected with surgical and medical procedures. In the majority of cases a few days is all the time that is required to arrive at the selection of the appropriate sex. Adequate facilities for the performance of these diagnostic tests are important considerations in the management of these infants since prolonged delay in assignment of sex always leads to undue psychological trauma to parents and relatives.

Equally as important as the diagnostic procedure is the manner in which the physician approaches the parents of the infant born with ambiguous genitalia. Nowhere in the field of medicine is there so much taboo, confusion, and misunderstanding on the part of laymen as in the area of sexual behavior. Parents should never be allowed to believe that their child is "half-boy and half-girl." Rather they must be made to understand that their child's problem is a birth defect which represents an arrest in the normal development of the genitourinary organs. It is this lack of complete development of the genitourinary organs which makes it difficult for the physician to decide on the exact sex of the infant without the aid of special studies. The parents must be convinced that the decision to be made for their baby is the only possible correct one. The importance of how they accept their child's ab-

From the Department of Pediatrics, University of Mississippi School of Medicine, Jackson, Miss.

normality as a true congenital defect (equal to any other birth defect) cannot be overemphasized. Any residual uncertainty they may have is quite likely to influence their child indirectly, sooner or later.

This paper will present a brief but pertinent review of the normal processes of sexual differentiation and the application of this knowledge to the work up and differential diagnosis of the infant with ambiguous genitalia. We hope that this information will be useful to the physicians engaged in the practice of medicine who will be faced with this dilemma from time to time.

Because an understanding of the normal processes of sexual differentiation is essential to the understanding of the abnormal, the first part of this paper will be devoted to a brief review of the embryology of sex differentiation, and of the scientific advances that have contributed to our understanding of the mechanisms underlying abnormalities in sex differentiation. The important advances which have brought about a clearer understanding of human intersexuality, its diagnosis and its management has taken place in the following areas: (a) in cytogenetics, the discovery of a histologic marker of sex and the ability to analyze human chromosomes; (b) in experimental embryology, the discovery of the control which the fetal gonad and hormonal factors have in sexual differentiation; (c) in biochemistry, the advances in steroid chemistry; (d) in psychiatry, the recognition of the influence which psychosexual orientation and the establishment of the gender role have in normal sexual behavior; and (e) in surgery, the development of corrective techniques for the treatment of these conditions.[1]

Figure 1 depicts in a schematic form the orderly sequence of changes which brings about the transformation of a sexually bipotential organism into either a male or female fetus. These changes, when complemented by the postnatal events of gender role and puberty, define the well adjusted and functional male or female adult.

Stage I—Chromosomal Stage. The discovery by Barr and his associates in 1949, of a clump of chromatin visible in the nuclei of female cells but absent from those of males provided a relatively simple method for assessing chromosomal sex.[2]

This body of heteropyknotic or darkly staining material is variously termed the nuclear chromatin, the sex chromatin, or the Barr body. Although there has been a long debate about its nature, it now seems reasonably clear that the Barr body represents most or all of the second X chromosome of the female cell. The Barr body has proved of great diagnostic value because of its relationship to the sex chromosome. It can be observed in fixed sections of many tissues, but is most readily found in freshly desquamated epithelial cells. For this purpose a buccal scraping or vaginal aspirate is more convenient.[3] The Barr body is first visible in the fifth day of fetal life; it is almost completely unaffected by age, nutrition, drugs, or hormonal status. Because of this constancy the nuclear sexing technique is an indispensable tool in the diagnosis of intersex syndromes and the most useful screening test for them.

It is now well accepted that the sex of the zygote at fertilization is established by a chromosomal mechanism which is dependent on normal meiosis.[4] Meiosis is the unique form of cellular division that takes place only in germ cells; it gives rise to gametes. The primary purpose of this specialized form of cell division is to produce cells with half the number of chromosomes appropriate for the particular species or the haploid chromosome complement. This process occurs in both sexes, but the details and timing are very different. In the male significant spermatogenesis begins at puberty; a single cycle occupies about 76 days from the onset of meiosis to shedding of mature sperm into the epididymis. The four gametes arising from each basal cell are equal in the amount of cytoplasm which they contain. A normal ejaculate contains three to five ml. of semen with 60 million to 200 million spermatozoa per ml.

In the female meiosis begins during the fourth month of fetal life and during the next three months proceeds to only part of its first meiotic division; then everything stops until puberty. At that time, stimulated by the pituitary gonadotropins, 8 to 12 eggs per month develop further, completing the first and beginning the second meiotic division. Usually only one of these undergoes ovulation; this egg does not complete the second meiotic division until after it is fertilized. The complexity of meiosis provides a number of opportunities for errors in gametogenesis to take place. There are two mechanisms which can produce gametes lacking in a sex chromosome. These are anaphase lag and nondisjunction. Structural anomalies of the sex chromosomes also figure in the pathogenesis of abnormal sexual differentiation.[1]

The role that the chromosomal sex plays in the prenatal stages of sexual development, namely the gonadal, ductal and external genitalia, have been significantly clarified by the advances in cytogenetics and experimental embryology, as

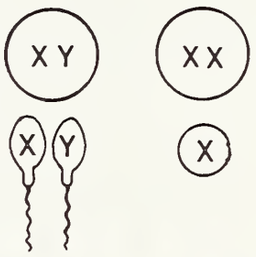
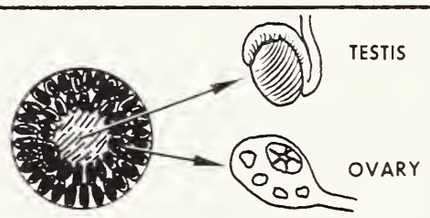
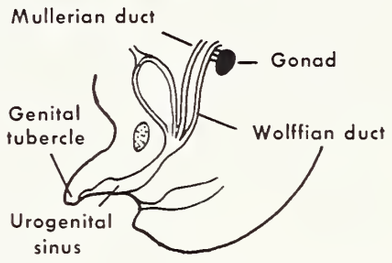
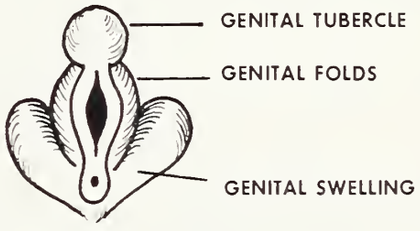
STAGE I	**Chromosomal**	
STAGE II	**Gonadal**	
STAGE III	**Ductal**	
STAGE IV	**External Genitalia**	
STAGE V	**Gender Role**	
STAGE VI	**Puberty**	

Figure 1. Schematic representation of sexual development. Stages I through IV prenatal, Stages V and VI postnatal.

well as the observation of patients with abnormal sex chromosomes and sexual development. From this observation it now appears that in the human the Y chromosome is a potent male determiner, and that two X chromosomes are needed for development of a normal ovary.

Once genetic sex is established, an orderly sequence of changes take place. These changes involve successively the gonads, the genital ducts, and external genitalia.

Stage II—Gonadal Stage. The primordial bipotential gonad arises from the coelomic epithelium by the fourth week of embryonic life; by the fifth week of gestation it is beginning to differentiate into a cortex and a medulla. Up to this point the process is the same in both sexes and the resulting structure is known as the indifferent gonad. Further development of the gonad will not proceed until after the arrival of the germ cells. These germ cells do not arise in the gonad but migrate from their origin in the ectoderm of the yolk sack. The cortical component of the undifferentiated gonad can develop only as an ovary, and the medullary component is capable of differentiating as a testis only. In the differentiation of the testes, the medullary portion of the embryonic gonad persists and the cortex disappears. The opposite takes place in ovarian development. Although the competitive relationship between cortex and medulla is gene controlled and the outcome normally is determined by genetic sex, a variety of conditions is capable of altering the balance between the cortex and medulla contrary to genetic sex. This results in abnormalities in sexual development which involve both the internal and external genitalia.

Stage III—Genital Ducts. This stage of sex differentiation involves the somatic sex organs, the genital ducts, and the lower genital tract. In embryos of both sexes Mullerian and Wolffian structures co-exist until the eighth week of fetal life. In normal female development, the Mullerian structures give rise to fallopian tubes, the uterus and the upper one-third of the vagina. An equally significant part of female development is the regression of the Wolffian system. This process begins during the third month of life. Conversely in the male the Wolffian ducts become the vasa differentia, the seminal vesicles, and the epididymis; the Mullerian structure regresses. The mechanisms responsible for these changes appear to be mainly hormonal and dependent on the sex and functional integrity of the fetal gonad.

Jost and others[5] have shown that in placental

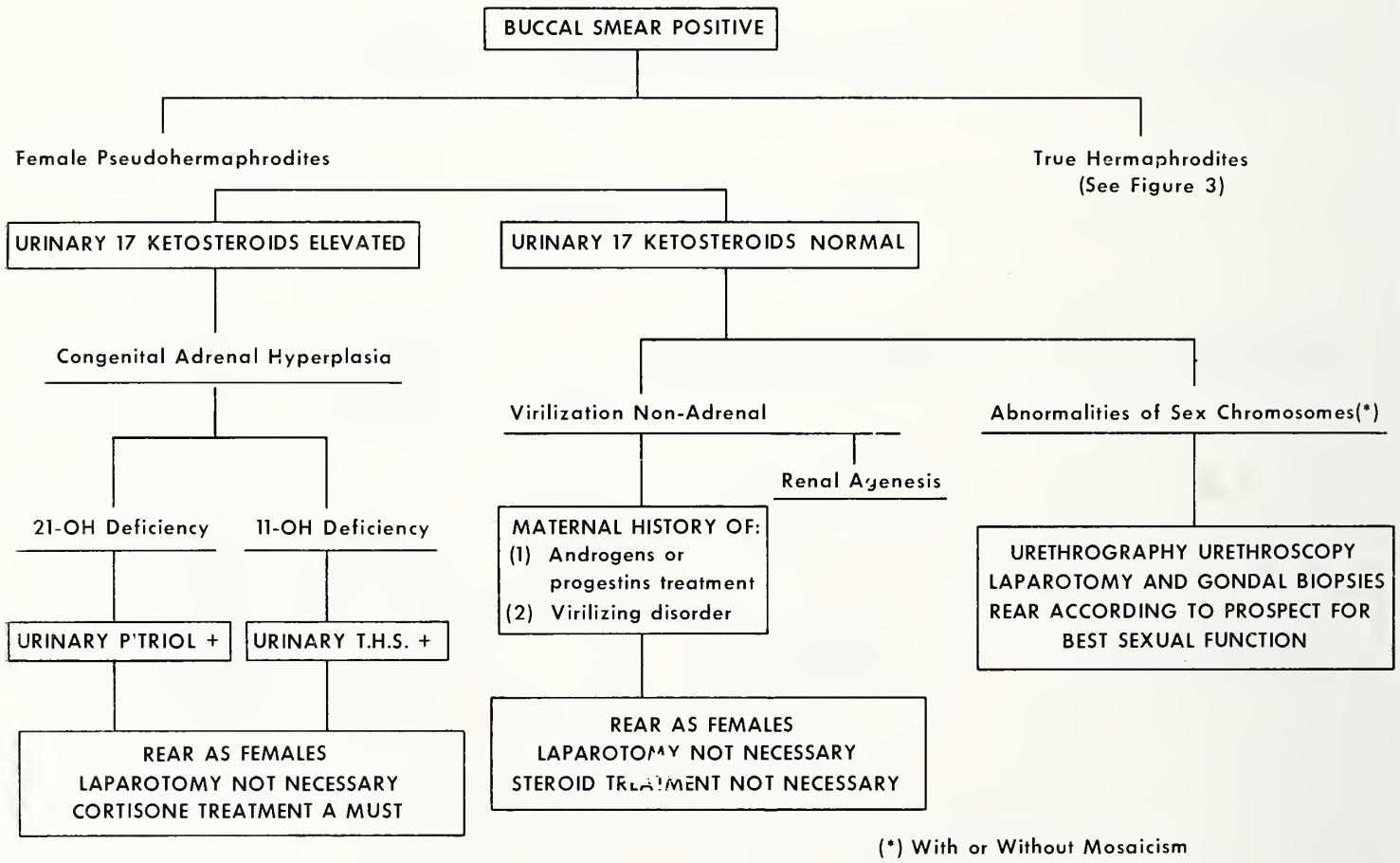


Figure 2. Flow chart for differential diagnosis and treatment of newborns with ambiguous genitalia in whom the buccal smear is found to be positive. Key diagnostic test and therapeutic procedures boxed in and in capital letters.

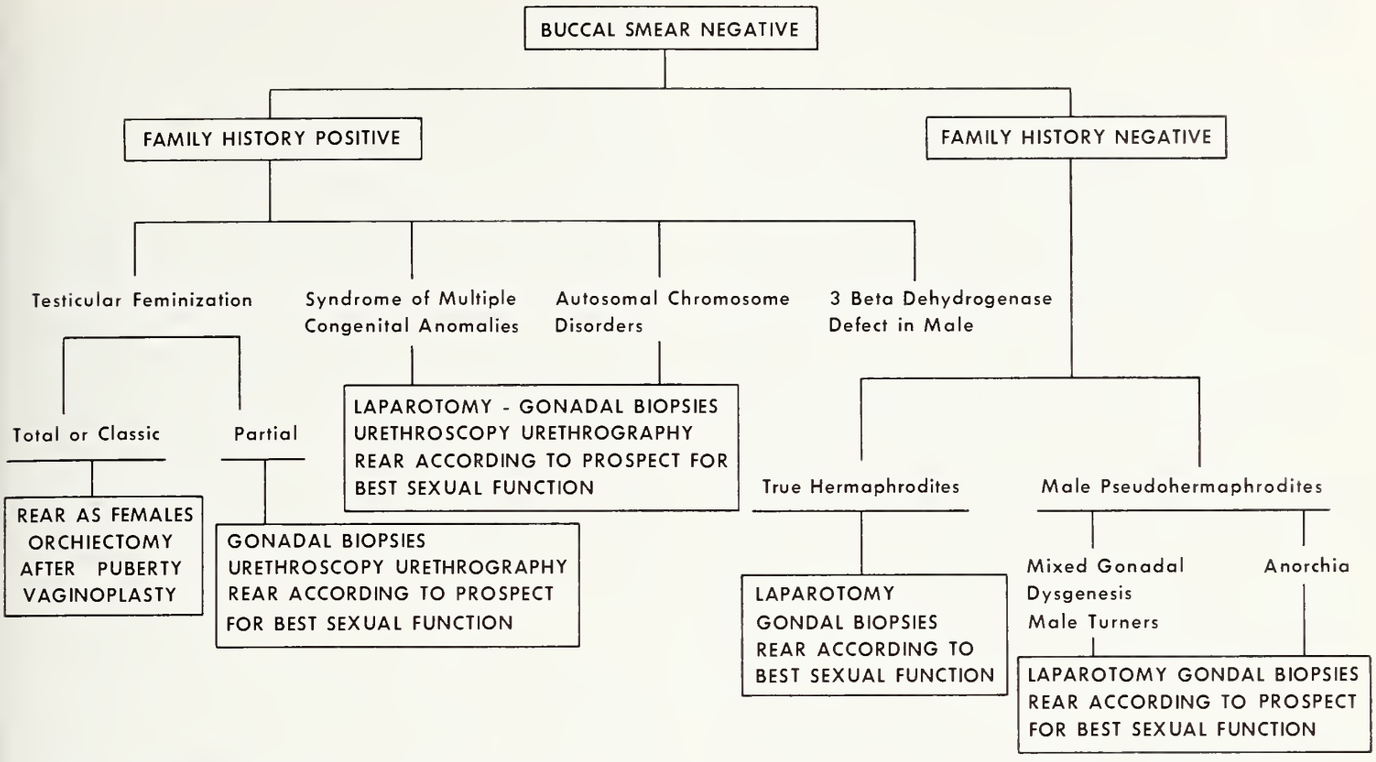


Figure 3. Flow chart for the differential diagnosis and treatment of newborns with ambiguous genitalia in whom the buccal smear is found to be negative. Key diagnostic test and therapeutic procedures boxed in and in capital letters.

mammals functional fetal testes are necessary for the fetus to develop along male lines. Removal of the fetal gonad results in development of the genital ducts and external genitalia along female lines irrespective of the sex chromosome. While it appears that a functional fetal gonad is not a prerequisite for the development of a female genital system, exposure of the female fetus to androgenic hormones can interfere and even arrest female differentiation of the urogenital sinus and external genitalia and induce masculinization.

Stage IV—External Genitalia. In contrast to the Wolffian and Mullerian ducts which are unipotential and capable only of differentiation into predetermined structures, the urogenital sinus and external genitalia are bisexual and have the capabilities of developing along masculine or feminine lines. The genital tubercle gives rise to the clitoris in the female, but with relatively little enlargement it becomes the penis in the male. The genital folds in the female become the labia minora; in the male they fuse to form the ventral raphe, the function of which is to displace the urethral opening to the tip of the penis. This process begins posteriorly and moves anteriorly; failure of this completion results in hypospadias and thus becomes a clue to imperfect virilization of the fetus. Finally the genital swelling forms the labia majora in the female but fuses in the midline to form the scrota in the male.

The fourth and final stage in the prenatal sex differentiation is of extreme importance because it provides the only external clue available to the clinician that something has gone wrong during embryogenesis.

State V—Gender Role. Gender role has been defined as "all of those things which a person says or does to disclose himself or herself as having the status of boy or man, girl or woman respectively. It includes, but is not restricted to sexuality in the sense of eroticism."[6] A gender role is not established at birth. Its course of differentiation is influenced by the experiences encountered and it is therefore dependent upon the postnatal stimulation of rearing in much the same way that language differentiation takes place. Genetic, hormonal or other prenatal determiners do not exercise a strong effect.

Parental attitude concerning the appearance and morphology of external genitalia, on the other hand, seems to play a definite role in psychosexual differentiation of all infants. While it is not possible to state a fixed age at which awareness of the gender role becomes established, it seems that somewhere around 18 months gender awareness begins and it has become well ingrained by 24 months in most instances. While this is a general guide, one must remember that in all aspects of development and maturation there is a normal variation.

The excellent studies of Money[7] dealing with psycho-sexual differentiation point out that gender role is so well established in most children by the age of two and one-half years that it is then too late to make a change of sex without the most complete psychiatric counseling, supervision, and follow up. While on the other hand, during the newborn period and in younger infants one has the freedom to assign either sex because psychosexual identity is still completely undifferentiated. It is now fairly well accepted and recommended that in assignment of sex to an infant with ambiguous genitalia, consideration be given first to the appearance and morphology of the external genitals.[8] If the external organs are so predominately male or so predominately female that no amount of surgical reconstruction will convert them to functional organs, then the sexual assignment should be dictated by the external genitalia alone. The most important exception to this dictum is, of course, the female pseudohermaphrodite with congenital virilizing adrenal hyperplasia. (Figure 4)

Stage VI—Puberty. The last stage in the orderly process of sexual maturation is puberty. Although the mechanism that initiates puberty is still poorly understood it is now accepted that the hypothalamus through the action of gonadotropin-releasing factors induces the secretion of gonadotropic hormones by the pituitary. In normal children puberty may begin at any time between the ages of 9 and 17 years. Therefore replacement therapy, when indicated, should not be started prior to the age of 9 nor delayed too much longer after the age of 17 years.

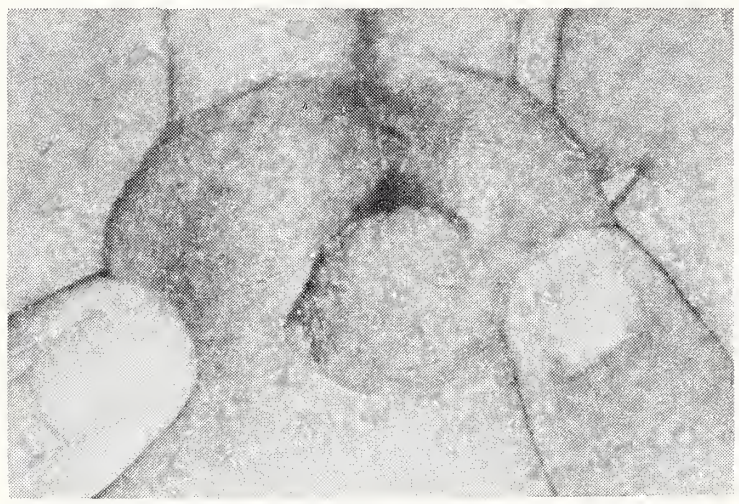


Figure 4. Photograph of the external genitalia of a six-week-old infant with congenital adrenal hyperplasia 21-OH deficiency with sodium loss.

A brief review of the normal sequences of events leading to sexual development and sexual maturation helps one understand how errors during embryogenesis can lead to the abnormal state not infrequently encountered in the practice of medicine.

Because the chromosomal stage is the earliest step in the determination of the sex of the individual and since the buccal smear is a simple and reliable test to identify chromosomal sex it will be used as the initial diagnostic test in the work up of these patients. Figure 2 outlines the diagnostic steps which should be followed in a patient with ambiguous genitalia in whom the buccal smear is positive. Figure 3 uses the same scheme for individuals with negative buccal smear. The figures are designed as flow charts with the key diagnostic tests boxed in and in capital letters.

BUCCAL SMEAR POSITIVE

Individuals with positive buccal smears are either true hermaphrodites or female pseudohermaphrodites. Approximately 60 per cent of the true hermaphrodites reported in a large series were found to have 46 XX chromosomal composition.[9]

Female pseudohermaphroditism results from the excessive amounts of virilizing hormones (androgens) either produced by the fetus itself (endogenous) or acquired through placental transfer (exogenous). The most common cause of female pseudohermaphroditism results from endogenous virilization of the female fetus secondary to an inborn error in the biosynthesis of cortisol. This condition is known as **congenital adrenal hyperplasia.**

Clinically there are three distinct forms of this syndrome. Defective steroid C-21 hydroxylation is the most common and it is of two types. The so-called simple or partial 21 hydroxylation deficiency and the complete or salt losing form of the syndrome. In both cases the result is virilization of the female fetus. The difference between the two is that in the complete form of 21 hydroxylase deficiency the individuals also have deficient production of aldosterone in addition to defective production of cortisol. The defective production of aldosterone leads to an inability to retain salt so that severe dehydration and shock usually occur in the first few weeks of life, unless the condition is recognized and treated.

Figure 4 shows a photograph of the external genitalia of a six-week old patient with the salt losing form of congenital adrenal hyperplasia in whom the male sex was assigned; however, at age five weeks the patient began to show signs of dehydration and vomiting and at six weeks of

age went into severe adrenal crisis. It was at this time that a correct diagnosis was made and replacement with cortisone and mineralocorticoids was instituted. Males with this syndrome will show no abnormalities of the external genitalia, but if they have the complete 21 hydroxylase deficiency, they frequently are not diagnosed until they come to autopsy. It has been postulated that the 4:1 female to male ratio observed with this syndrome reflects lack of diagnosis with resulting death of the male infants with the salt losing form of the syndrome.

The other clinical form of the syndrome is that associated with the 11 hydroxylase deficiency. These individuals also have cortisol deficiency but in addition they have severe hypertension because of the excessive accumulation of desoxycorticosterone (DOC) secondary to the enzymatic block in the synthesis of cortisol.

The diagnosis of these syndromes is confirmed by finding in the urine elevated levels of 17 ketosteroids. In addition to the elevated urinary levels of 17 ketosteroids, the presence of high levels of urinary pregnanetriol is diagnostic of the 21 hydroxylase deficiency. The 11 hydroxylase deficiency can be recognized by the presence of T.H.S. in the urine.

The group of patients with female pseudohermaphroditism secondary to exogenous androgens falls into three main categories and is characterized by having normal urinary levels of 17 ketosteroids and no other abnormal metabolite present in the urine.

MATERNAL VIRILIZATION

In the category of maternal virilization one finds virilization secondary to the administration of androgenic steroids to the pregnant mother within the first 90 days of pregnancy. Virilizing maternal tumors have also been reported as causing female pseudohermaphroditism in female fetuses.[10, 11]

The following natural and synthetic compounds have been implicated as causes of ambiguous genitalia in female infants: testosterone, 17 methyltestosterone, 17 alpha ethinyl-19 nortestosterone (northindrome, Norlutin), 17 alpha ethyl-19 nortestosterone (norethandrolone, Nilevar), 17 alpha ethinyl testosterone (anhydroxyprogesterone, ethisterone, Progesterol, Pranone, Lutocyl-ol), 17-methyl-androstenediol, diethyl-stilbestrol, progesterone, mixtures of ethinyl estradiol 3 methylester and 17 alpha ethinyl-19 nortestosterone (Ortho Novum), 17 alpha hydroxyprogesterone.[12]

In **renal agenesis,** it has been postulated that the masculinization of the female fetus with renal agenesis may be the result of diminished excretion of steroid hormone by the fetal kidney.[13]

Ambiguous genitalia may result from the presence of a mixture of cells with different sex chromosomal composition, some having Y chromosomes and others not. The following karyotypes have been described: XX/XY mosaicism, XO/XY mosaicism, XO/XX/XY mosaicism, XO/XXXY mosaicism, XO/X plus deleted Y mosaicism, X plus deleted Y, X plus abnormally long Y.[12]

BUCCAL SMEAR NEGATIVE

Individuals with negative buccal smears are either male pseudohermaphrodites or true hermaphrodites. Male pseudohermaphrodites usually follow in one of two categories, those in whom there is a positive family history of other individuals with similar abnormalities and those in whom no family history can be obtained. The following group of syndromes is associated with family history.

Testicular feminization, total or classic, is characterized by patients who have a XY chromosomal composition, female body habitus, female breasts, female external genitalia, normal clitoris, a vagina ending in a blind pouch, and rudimentary uterus and testes. The testes may be located intra-abdominally or in the inguinal canal where they are frequently associated with hernias.[14] Total or classical testicular feminization often is not diagnosed during childhood except as labial masses or inguinal hernias. At surgery the gonads are found in the hernial sac and identified as testicles. Because this defect apparently is an end-organ insensitivity to testosterone, it is recommended that the gonads be left in place until after puberty since the endogenous hormone production usually results in adequate feminization. Replacement therapy is not required prior to orchiectomy.

The other form of the testicular feminization syndrome is partial testicular feminization. This group of patients is like those with the complete syndrome except that the external genitalia are ambiguous and they may or may not feminize at adolescence. The structure of the external genitalia in partial testicular feminization varies greatly from case to case with some having a normal size penis with glandular hypospadias and small scrotal testes, and others having a very small phallus with chorde deformity, perineal hypospadias and undescended testes. Figure 5 shows two siblings, one with the complete form and the other with the partial form of the syndrome.

Various investigators have reported defective development of the genitalia occurring in hereditary syndromes in which there is no obvious de-

fect in the testes.[12] Most of these patients have severe congenital anomalies and mental retardation.

Abnormalities of the autosomal chromosome also appear to result in abnormal development of external genitalia in some cases. One such example is that of the patient with the D trisomy syndrome in whom cryptorchidism and abnormal scrotal development is present.[15]

Three beta hydroxysteroid dehydrogenase in the male is an extremely rare congenital defect in the biosynthesis of cortisol described by Bongiovanni[16] in which the affected males may have ambiguous genitalia presumably because the inherited defect affects the synthesis of androgens by testicular Leydig cells.

True hermaphroditism represents an error during the second (gonadal) stage of sexual development. It is characterized by incomplete differentiation of the medullary and cortical component of the fetal gonad (dysgonadogenesis). The incomplete differentiation of the fetal gonad results in individuals with both ovarian and testicular tissue present.

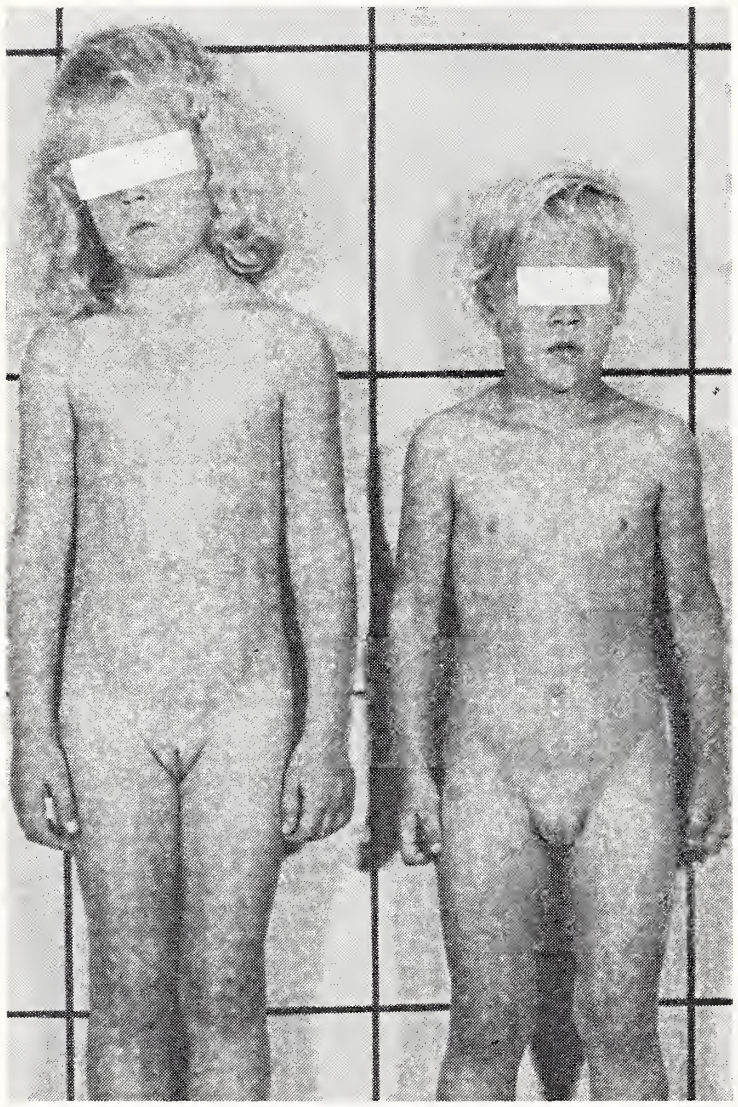


Figure 5. Photograph of two siblings with testicular feminization syndrome. Normal karyotype with XY composition. Patient on left has the complete form of syndrome, normal female external genitalia; patient on right has the partial form with clitoral hypertrophy and labial masses.

About 40 per cent of the patients with true hermaphroditism have an ovary on one side and a testis on the other; 20 per cent have bilateral ovotestes; the remainder have an ovary or testis on one side and ovotestes on the other. The abnormalities of the external genitalia vary considerably.[9] In some two-thirds of the patients, the external genitalia were masculinized sufficiently for the patients to have been reared as males with some having hypospadias. Only three of the ones reared as females had normal female external genitalia. On the basis of morphology of the internal or external genitalia it is impossible to distinguish true hermaphroditism from other forms of intersex.

Perhaps the mildest form of male pseudohermaphroditism is that which has been occasionally reported with the so-called "male" Turner's syndrome. The findings are usually hypoplastic testes, cryptorchidism and hypospadias.[17] The genital anomalies are not usually of sufficient severity to cause doubt about the proper sex of rearing. The basis of the cause of this syndrome has not been worked out.

Jost[5] was the first to demonstrate that the removal of the fetal testes, **anorchia,** always resulted in development of the male fetus along female lines. Bergada et al[18] described four patients with an XY chromosomal constitution and ambiguous genitalia in whom no gonadal tissue was found at exploration.

Once a definite diagnosis has been made, the clinician then has three main tasks to perform. First of all is the selection of the best sex of rearing for his patient. This depends primarily on the etiology of the condition and the prospect for the best sexual function obtainable. The second task is the correction of the defect responsible for the production of the condition in utero, such as in the patient with congenital adrenal hyperplasia, in whom corticosteroid replacement therapy is essential to prevent further masculinization and even death. Thirdly, there is the recognition of the need for long-term follow up so that replacement therapy can be instituted at the time of puberty, and regulated thereafter.

SUMMARY

The assignment of sex to a newborn infant with ambiguous external genitalia requires at least three basic diagnostic procedures: (1) a complete maternal and familial history, (2) a

buccal smear for the determination of nuclear sex, and (3) determination of urinary levels of 17 ketosteroids.

Delay of assignment of sex beyond the first week of life usually brings about undue psychological trauma to parents and relatives. The establishment of gender role is strongly influenced by the parental attitudes; therefore, parental acceptance and understanding of their child's abnormality is essential.

Re-assignment of sex after two and one half years of age requires expert psychiatric guidance. Cortisone replacement and endocrine follow up is necessary in cases of congenital adrenal hyperplasia. Hormonal replacement therapy, when indicated, should be started at an age which would coincide with the normal onset of puberty. ★★★

2500 North State Street (39216)

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QUICK THINKING

The professor stepped on the platform, and by way of breaking the ice, remarked: "I've been asked to come up here and say something funny."

A student heckler called out: "You'll tell us when you say it, won't you?"

The professor answered: "I'll tell you. The others will know."

Radiologic Seminar CVI: Air Inside Gallstones

JOSEPH C. GRIFFING, M.D.
Picayune, Mississippi

GAS IN THE BODY CAN be a valuable contrast media. We may inject gases into the body and often natural gas shadows aid in diagnosis. It's extremely rare to find gas in gallstones, but it does happen.

About 5 per cent to 10 per cent of gallstones contain enough calcium to be seen on plain films. The remainder are nonopaque but become visible when contrast media fills the gallbladder. This organ may not concentrate the media however, especially if chronically inflamed. In this instance, a valuable x-ray sign is faint gas streaks in the gallbladder area—air which is actually inside stones.

The gas streaks measure less than one centimeter in length and their number depends on the number of stones present. They may have the shape of a tiny cross or star (stellate configuration). If the gallstones are large, the air shadows may resemble a bird's foot.

CASE REPORT

E. W., a 58-year-old female, complained of belching and fatty food intolerance of two years duration. Slight tenderness was present over the right upper quadrant. Her urinalysis and CBC were normal.

A KUB film on admission showed typical stellate translucencies in the gallbladder area and a diagnosis of cholelithiasis was made. Routine cholecystogram films failed to outline the gallbladder but the same star-like streaks were again noted. She was discharged from the hospital with 20 Telepaque tablets and instructions to take five pills daily for four days. Upon reexamination, her gallbladder was nicely outlined and three large radiolucent stones were present, all containing the same air streaks.

PATHOGENESIS

The phenomenon of fissured gallstones containing gas is well known to pathologists. They may see these at autopsy and when the stones are broken under water, an odorless gas escapes. Nobody knows how gas gets inside the stones. It may be produced by bacterial decay.

Only 14 cases are recorded in the literature although most radiologists have observed this rare finding. Films of superb diagnostic quality are needed to visualize the subtle streaks. The

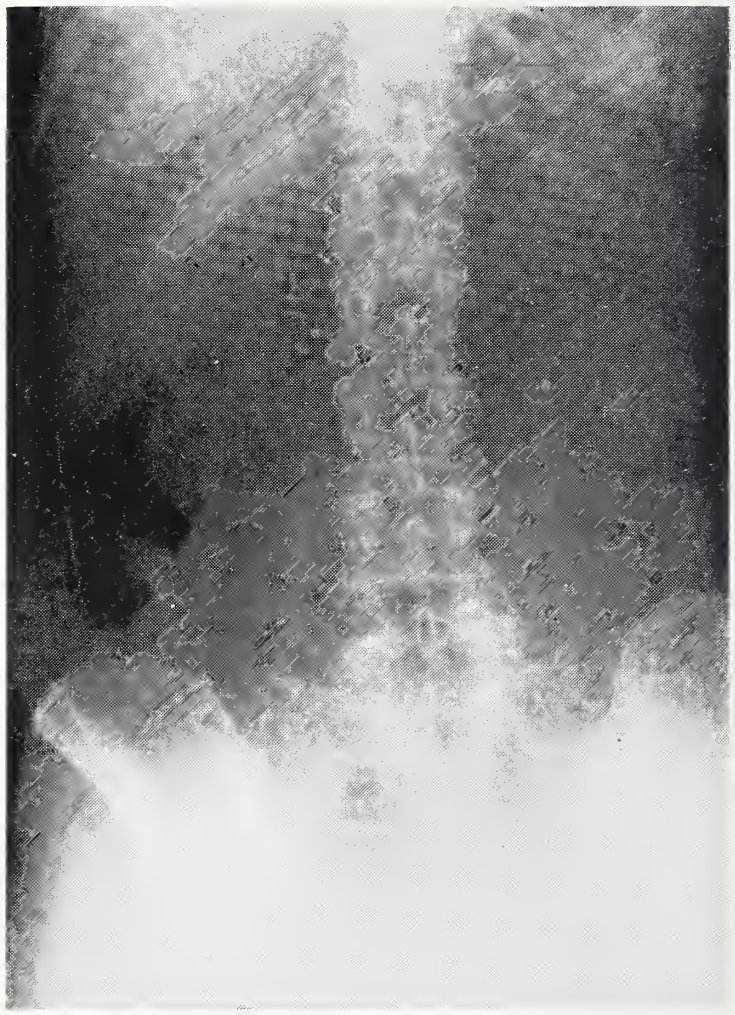


Figure 1. Initial film showing the right upper quadrant free of bowel gas but faint gas streaks are seen in gallstones just below the twelfth rib.



Figure 2. After 12 Telepaque tablets the gallbladder did not concentrate but once again, the same stellate gas shadows are visible in stones.



Figure 3. After daily doses of Telepaque three large radiolucent gallstones become visible and all contain faint star-like gas streaks.

radiologist must distinguish them from confusing bowel gas shadows. The faint radiolucencies do not change from one day to the next. High dose cholecystography often confirms the diagnosis before surgery.

In conclusion, gallstones were diagnosed by demonstrating persistent gas streaks inside the stones. Careful attention to technique and a suspicious eye for bird tracks in the right upper quadrant are stressed. ★★★

L. O. Crosby Memorial Hospital (39466)

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OUT OF THE MOUTHS OF BABES

The teacher asked her third graders why the Pilgrims had come to America. She got the quick reply, "So they could worship in their own way and make other people do the same."

Counsel to Authors

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103rd Annual Session

Mississippi State Medical Association
May 3-6, 1971
Biloxi

MISSISSIPPI'S GULF COAST will become the state's medical capital May 3-6 as the 103rd Annual Session of the association meets at the new Sheraton-Biloxi. Six general scientific sessions involving the seven formal sections, over a dozen specialty groups, four medical alumni occasions, technical and scientific exhibits, the House of Delegates, and a host of fellowship events are slated for the four-day meet.

Dr. Paul B. Brumby of Lexington, association president, will address the opening meeting of the House of Delegates on May 3. House Speaker William E. Lotterhos of Jackson and Vice Speaker John B. Howell, Jr., of Canton said that reports and resolutions will be presented at the opening meeting. Final actions will come on May 6 when 1971-72 officers are elected.

Dr. Arthur E. Brown of Columbus will be inaugurated president for the new year during closing ceremonies on the final day.

Dr. Raymond S. Martin, Jr. of Jackson said that the Scientific Assembly will open on Tuesday morning, May 4, and continue through Thursday noon. Dr. Martin heads the group which has planned and scheduled the general and specialty sessions, exhibits, and fellowship occasions.

Principal speaker for the annual session is Dr. Walter C. Bornemeier of Chicago, president of the American Medical Association. He is scheduled to address the opening meeting of the House of Delegates on May 3, Dr. Brumby said.

The Woman's Auxiliary will conduct its 48th Annual Session concurrently during May 3-4, also headquartering at the Sheraton-Biloxi, according to Mrs. Curtis W. Caine of Jackson, state president. Mrs. T. E. Ross III of Hattiesburg will be inaugurated 1971-72 president at the meeting. General chairman for the ladies' meet is Mrs. Mal S. Riddell, Jr., of Winona.

Medical alumni occasions are set for Monday and Tuesday evenings, and the association cocktail party and fellowship hour is the Wednesday feature.

The just-opened Sheraton-Biloxi luxury hotel will host the 103rd. Located immediately east of the Broadwater Beach Hotel, the new complex consists of a nine-story tower fronting on the Gulf with five connected two- and three-story lanai units on the north or back. There are 300 rooms and suites and 30,000 square feet of public space for meetings and exhibits. The Sheraton-Biloxi is accepting reservations subject to sell-out, after which registrants will be given priority at the adjacently-sited Ramada Inn.

OFFICIAL CALL

To all members of the Mississippi State Medical Association:

The 103rd Annual Session of the Mississippi State Medical Association is called to meet at Biloxi, Mississippi, on Monday, May 3, 1971, pursuant to Article V of the Constitution. The House of Delegates will be convened at 9 o'clock in the morning at the Sheraton-Biloxi on May 3.

The Scientific Assembly, consisting of the general sessions, will meet during May 4-6, 1971.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

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RAYMOND S. MARTIN, JR.
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Temple Ainsworth, Jackson	1967-68
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James L. Royals, Jackson	1969-70

ACTIVITIES CALENDAR

REGISTRATION

General Registration for the Scientific Assembly and House of Delegates will be located at the second level (Grand Ballroom and Gulf Rooms) in the Sheraton-Biloxi. No person may be admitted to any activity of the annual session without first registering. Hours of registration will be 1:00 to 4:00 p.m. Sunday, May 2; 8:00 a.m. to 5:00 p.m., Monday, Tuesday, and Wednesday, May 3-5; and 8:00 a.m. to 2:00 p.m. Thursday, May 6. The Secretary's Office will be located off the West Lobby on the second level.

SUNDAY, MAY 2, 1971

1:00 p.m. Miss. Association of Pathologists, Executive Committee, Biloxi Room
2:00 p.m. Miss. Association of Pathologists, Business Meeting, Biloxi Room
2:00 p.m. Miss. Radiological Society, Broadwater Beach Hotel
6:00 p.m. Miss. Society of Anesthesiologists, Country Club of Jackson (Jackson, Miss.)
7:00 p.m. Miss. Association of Pathologists, Cocktail Party, Gulf Room A

MONDAY, MAY 3, 1971

7:00 a.m. Reference Committees Breakfast, Gulf Room D
9:00 a.m. House of Delegates, Top of the Sheraton
9:00 a.m. Miss. Association of Pathologists, Gulf Room C
12:00 noon Miss. Orthopaedic Society, Luncheon and Meeting, Gulf Room D
12:30 p.m. Miss. Urological Society, Luncheon and Meeting, Boston Room
1:30 p.m. Reference Committee on Reports of Officers and Board of Trustees, Gulf Rooms A and B
1:30 p.m. Reference Committee on Miscellaneous Business, Gulf Room C
3:00 p.m. Reference Committee on Medical Practices, Gulf Room C
3:30 p.m. Council on Constitution and By-Laws, Gulf Rooms A and B
4:00 p.m. Ole Miss Medical Alumni Business Meeting, Boston Room
4:00 p.m. Woman's Auxiliary, Finance Committee, Directors Room
6:00 p.m. Miss. Orthopaedic Society Cocktail Party, Biloxi Room
7:00 p.m. Ole Miss Medical Alumni Cocktail Party, Gulf Rooms A, B, C, and D

8:00 p.m. Ole Miss Medical Alumni Seafood Jamboree and Dance, Grand Ballroom West

TUESDAY, MAY 4, 1971

7:30 a.m. Committee on Medicine and Religion Breakfast, Boston Room
8:00 a.m. Woman's Auxiliary Preconvention Board of Directors Continental Breakfast and Meeting, Top of the Sheraton
9:00 a.m. General Scientific Session, Grand Ballroom West
9:00 a.m. American College of Surgeons, Gulf Room B
9:30 a.m. Woman's Auxiliary General Session, Gulf Room A
12:00 noon Miss. Ob-Gyn Society Luncheon, Gulf Room D
12:00 noon Fifty Year Club Luncheon, Boston Room
12:30 p.m. American College of Surgeons Luncheon, Gulf Room C
1:00 p.m. Woman's Auxiliary Luncheon, Top of the Sheraton
1:00 p.m. Scientific Film Session, Grand Ballroom West
2:00 p.m. General Scientific Session, Grand Ballroom West
4:00 p.m. Woman's Auxiliary Postconvention Board of Directors Meeting, Biloxi Room
5:30 p.m. Vanderbilt Medical Alumni Cocktail Party, Gulf Room C
5:30 p.m. Tulane Medical Alumni Cocktail Party, Gulf Room D
6:00 p.m. Tennessee Medical Alumni Cocktail Party and Dinner, Gulf Rooms A and B

WEDNESDAY, MAY 5, 1971

7:30 a.m. MSMA Past Presidents' Breakfast, Boston Room
8:30 a.m. Woman's Auxiliary Past Presidents' Breakfast, Biloxi Room
9:00 a.m. General Scientific Session, Grand Ballroom West
12:00 noon Miss. Society of Internal Medicine Luncheon, Boston Room
12:00 noon Miss. Academy of General Practice Luncheon, Top of the Sheraton
12:30 p.m. Scientific Film Session, Grand Ballroom West
1:30 p.m. General Scientific Session, Grand Ballroom West
1:30 p.m. Nominating Committee, Gulf Room A
6:00 p.m. Annual Association Cocktail Party, Grand Ballroom West

THURSDAY, MAY 6, 1971

9:00 a.m. General Scientific Session (EENT), Gulf Rooms A and B
9:30 a.m. General Scientific Session (Pediatrics), Grand Ballroom West
12:00 noon Miss. EENT Association Luncheon, Gulf Room D
1:30 p.m. House of Delegates, Grand Ballroom West

EXECUTIVE BUSINESS



DR. LOTTERHOS

HOUSE OF DELEGATES

Monday, May 3, 1971
9:00 a.m.

Gulf Room
Sheraton-Biloxi

William E. Lotterhos
Jackson, Speaker

John B. Howell, Jr.
Canton, Vice Speaker



DR. HOWELL

MEETINGS OF THE HOUSE OF DELEGATES

The opening meeting of the House will be called to order by the President, and the Speakers will announce the order of business. An open meeting, to which all members and ladies of the Auxiliary are invited, will feature addresses by Dr. Paul B. Brumby, the president, and Dr. Walter C. Bornemeier, president of the American Medical Association. The adjourned meeting of the House will convene in the Gulf Room at 1:30 p.m. on May 6.

REFERENCE COMMITTEES

Reports of Officers and Board of Trustees, May 3, Gulf Rooms A and B, 1:30 p.m.

Miscellaneous Business, May 3, Gulf Room C, 1:30 p.m.

Medical Practices, May 3, Gulf Room C, 3:00 p.m.

Constitution and By-Laws, May 3, Gulf Rooms A and B, 3:30 p.m.

Nominating Committee, May 5, Gulf Room A, 1:30 p.m.

THE SCIENTIFIC ASSEMBLY

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Dr. Martin

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SCIENTIFIC AND TECHNICAL EXHIBITS

Grand Ballroom
Sheraton-Biloxi

CONDUCT OF THE SCIENTIFIC ASSEMBLY

The order of exercise, papers, and discussion as set forth in the official program shall be followed until completion. All papers read before the association shall become its property. Each paper must be read by its author and deposited with the Secretary (or Chairman) when read.

THE SCIENTIFIC EXHIBIT

Physicians, foundations, organizations, and major medical institutions will present the Scientific Exhibit. Physician-members of the Mississippi State Medical Association are eligible for the Aesculapius Award, an honorarium cash purse, given for excellence of presentation, quality of content, and originality. Others may not participate in this competition, but they are eligible for the association's Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a nonmember. The Scientific Exhibit is located in the Grand Ballroom.

EXHIBITS AND AUTHORS

"Abdominal Angiography"
Ottis G. Ball and Fred A. Lewis, Department of Radiology, Mississippi Baptist Hospital, Jackson

"Hemodialysis—Patient Demonstration"
John D. Bower, Director of Artificial Kidney Unit, University Medical Center, Jackson

"The Treadmill Exhibit"
James C. Hays and William H. Rosenblatt, Jackson

"Modern Radiotherapy: A Vital Aid in Cancer Management"
B. T. Hickman, W. M. Flowers, and J. O. Morris, Department of Radiology, University Medical Center, Jackson

"Ventricular Resection Following Myocardial Infarction"
Hector S. Howard, H. Edward Garrett, and J. T. Davis, Jr., Memphis

"Surgical Aspects of Coronary Disease"
Thomas L. Kilgore, J. Harvey Johnston, Jr., W. C. Shands, and James C. Griffin, Jr., Jackson

"Practical Considerations in Biliary Surgery"
Jack B. Campbell and Edward M. Lowicki, Jackson

"Malignant Abdominal Tumors of Childhood"
Patricia C. Moynihan and Richard C. Miller, Department of Surgery, University Medical Center, Jackson

"Cardiopulmonary Resuscitation—the Physician's Responsibility"
Mississippi Heart Association

"Cystic Fibrosis in the First Year of Life"
Suzanne T. Miller, Wilfred Q. Cole, and Richard C. Miller, Department of Pediatrics, University Medical Center, Jackson

"Congenital Heart Disease—Management of 100 Consecutive Cases"
Hilary H. Timmis, James D. Hardy, and David G. Watson, Department of Surgery, University Medical Center, Jackson

"Management of Breast Lumps"
James P. Spell, Jackson

"New Diagnostic Procedures for Lung Cancer"
Carlos M. Chavez, Jack Ratliff, James D. Hardy, J. Harold Conn, and Pandeli Anas, Department of Surgery, University Medical Center, Jackson

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OLE MISS MEDICAL ALUMNI

University of Mississippi Medical Alumni, their ladies, and guests will meet on Monday, May 3, at the Sheraton-Biloxi. Alumni registration will be located adjacent to general registration in the second level lobby and will be open at 8:00 a.m. where tickets for the evening party will be available. A general business meeting will be conducted at 4:00 p.m. in the Boston Room (main lobby arcade). The cocktail party is in Gulf Rooms A, B, C, and D at 7:00 p.m., and the Seafood Jamboree dinner-dance will be in the Grand Ballroom West at 8:00 p.m. Dr. Robert H. Middleton, Jr., of Biloxi is program chairman. Officers are Drs. Paul H. Moore of Pascagoula, president; J. Dan Mitchell of Jackson, president-elect; and Mr. Charles William Price of Jackson, secretary. Further details and tickets may be secured from Mr. Price at the Ole Miss Medical Alumni House, UMC Campus, Jackson.

THE TECHNICAL EXHIBIT

The Mississippi State Medical Association presents with pride the 1971 Technical Exhibit. Established firms engaged in the manufacture and distribution of pharmaceuticals, supplies, equipment, and in providing varied services will present exhibits. Visit each exhibit often and discuss products and services with the Professional Service Representatives. Only registered members and guests are admitted. The Technical Exhibit is located in the Grand Ballroom.

EXHIBITORS	BOOTH
Abbott Laboratories, North Chicago, Ill.	21
Ayerst Laboratories, New York, N. Y.	49
Bedsole Surgical Supply Company, Mobile, Ala.	5
Bristol Laboratories, Syracuse, N. Y.	34
Coca-Cola USA, Atlanta, Ga.	3
Financial Service Corporation, Brookhaven, Miss.	4
Hoechst Pharmaceutical Company, Somerville, N. J.	8
Kay Surgical, Inc., Jackson, Miss.	20
Lanier Business Products, Jackson, Miss.	31
Massachusetts Mutual Life Insurance Co., Jackson, Miss.	50
McNees Medical Supply Co., Jackson, Miss.	33
Merrill Lynch, Pierce, Fenner and Smith, Jackson, Miss.	32
Mississippi Hospital and Medical Service, Jackson, Miss.	47
Parke, Davis and Co., Detroit, Mich.	1
William P. Poythress and Co., Richmond, Va.	9

A. H. Robins Company, Richmond, Va. 33
William H. Rorer, Inc., Fort Washington, Pa. 48
Sandoz Pharmaceuticals, Hanover, N. J. 2
Savage Laboratories, Inc., Houston, Texas 19
Stuart Pharmaceuticals, Pasadena, Calif. 22
Travelers Insurance Co., Jackson, Miss. 6

SCIENTIFIC GRANTS

Geigy Pharmaceuticals, Ardsley, N. Y.

Eli Lilly and Company, Indianapolis, Ind.

REGISTRATION FOR EXHIBIT PRIZES

Visit the Technical Exhibits often and qualify for the drawing of attractive prizes. Obtain necessary initials as you visit each booth. Deposit cards at Registration not later than 12:30 p.m., Thursday, May 6.

TENNESSEE MEDICAL ALUMNI

Medical alumni of the University of Tennessee will enjoy cocktails and dinner on Tuesday evening, May 4, in Gulf Rooms A and B at 6:00 p.m. Dr. Sidney O. Graves of Natchez is chairman, and Mr. June Montgomery, UT director of Alumni Affairs, will be present.

SCIENTIFIC PROGRAM

Tuesday, May 4, 1971
Grand Ballroom
Beginning at 9:00 a.m.

William S. Cook, Jackson
Chairman

Warren C. Plauche, Biloxi
Secretary



DR. COOK

CANCER OF THE CERVIX: A COMPARISON OF TWO RADIOTHERAPEUTIC PLANS
Richard Boronow, Jackson

EASIER METHODS OF CALCULATING RADIATION DOSAGE
Melvin Flowers, Jackson

DIAGNOSTIC USE OF AMNIONIC FLUID
Maxwell Cooke, Jackson

ASSOCIATION OF FIBROIDS AND HYPERTENSION
Calvin Hull, Jackson

VISIT THE EXHIBITS

SCIENTIFIC PROGRAM

Tuesday, May 4, 1971
Grand Ballroom
Beginning at 2:00 p.m.

M. Beckett Howorth, Jr., Oxford
Chairman

Benton M. Hilbun, Tupelo
Secretary



DR. HOWORTH

THE SHOCK LUNG, CAUSES AND MANAGEMENT
Watts R. Webb, Syracuse, New York

SURGICAL MANAGEMENT OF MALIGNANT TUMORS IN CHILDHOOD
Judson G. Randolph, Washington, D. C.

THE OPERATIVE MANAGEMENT OF HEART FAILURE
James D. Hardy, Jackson

NEW DEVELOPMENTS IN THE MANAGEMENT OF NECK AND BACK PAIN PROBLEMS
Bernard S. Patrick, Jackson

SCIENTIFIC PROGRAM

Wednesday, May 5, 1971
Grand Ballroom
Beginning at 9:00 a.m.

C. Ralph Daniel, Jr., Jackson
Chairman

S. H. McDonnieal, Jr., Jackson
Secretary



DR. DANIEL

NEWER CONCEPTS OF HEMOLYTIC DISEASE
Ralph L. Nachman, New York City

NEWER CONCEPTS ON LEUKOCYTES AND GRANULOCYTES
Warren N. Bell, Jackson

NEWER TREATMENT OF LEUKEMIA AND LYMPHOMA
Guy T. Gillespie, Jr., Jackson

ALLIED HEALTH PERSONNEL IN THE INTERNIST'S OFFICE
Frank A. Riddick, Jr., New Orleans

SCIENTIFIC PROGRAM

Wednesday, May 5, 1971
Grand Ballroom
Beginning at 1:30 p.m.

Hugh B. Cottrell, Jackson
Chairman

Frank M. Wiygul, Jr., Jackson
Secretary



DR. COTTRELL

CURRENT TRENDS IN COMMUNICABLE DISEASES
James H. McGee, Atlanta

A REVIEW OF THE MISSISSIPPI MEDICAID PROGRAM
Alton B. Cobb, Jackson

SCIENTIFIC PROGRAM

Wednesday, May 5, 1971
Grand Ballroom
Beginning at 3:00 p.m.

James O. Stephens, Magee
Chairman

W. Johnson Witt, Jackson
Secretary



DR. STEPHENS

RECENT ADVANCES IN DIAGNOSIS AND TREATMENT OF CORONARY ARTERY DISEASE
H. Davis Dear, Jackson

STRICTURES OF THE MALE URETHRA
W. L. Weems, Jackson

SUBCUTANEOUS BREAST RESECTION FOR CHRONIC CYSTIC MASTITIS
J. H. Hendrix, H. C. Ethridge, and W. Douglas Godfrey, Jackson

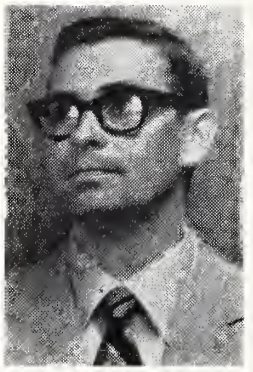
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SCIENTIFIC PROGRAM

Thursday, May 6, 1971
Grand Ballroom
Beginning at 9:30 a.m.

John D. McEachin, Meridian
Chairman

John R. Jackson, Jr., Hattiesburg
Secretary



DR. MCEACHIN

COMMON DERMATOLOGIC DISORDERS IN CHILDREN
Ronald R. Lubritz, Hattiesburg

COMMON LOWER EXTREMITY PROBLEMS IN CHILDREN
Wiley C. Hutchins, Memphis

RECENT DEVELOPMENTS IN THE PHARMACOLOGIC TREATMENT OF ASTHMA
Faser Triplett, Jackson

SCIENTIFIC PROGRAM

Thursday, May 6, 1971
Gulf Rooms A & B
Beginning at 9:00 a.m.

Richard L. Blount, Jackson
Chairman

James K. Williams, Jr., Pascagoula
Secretary



DR. BLOUNT

THE X-RAY DIAGNOSIS OF ACOUSTIC TUMORS
Michael E. Glasscock, III, Nashville

LOW VISION AIDS
Roger L. Hiatt, Memphis

RECENT ADVANCES IN CHRONIC EAR SURGERY
Dr. Glasscock

SURGERY OF CONGENITAL CATARACTS
Dr. Hiatt

A SURGICAL TECHNIQUE FOR CONGENITAL CATARACTS
Donald L. Hall and James R. Russell, Jackson

TULANE MEDICAL ALUMNI

Medical graduates of the Tulane University will be feted at an informal cocktail party on Tuesday evening, May 4, in Gulf Room D (second level) at 5:30 p.m. Dr. Robert A. Little of Mississippi City is chairman, and Dr. Marshall L. Michel, president of the Tulane Medical Alumni Association, will be present. Dr. M. E. Lapham, executive secretary of the association, and Mrs. Rose B. Koppel, administrative assistant, are aiding in arrangements.

VANDERBILT MEDICAL ALUMNI

Vanderbilt Medical Alumni will met at a reception on Tuesday, May 4, at 5:30 p.m. in Gulf Room C (second level). Co-chairmen for the occasion are Drs. Archie C. Hewes and Edward C. Hamilton of Gulfport. Assisting is Mrs. Margaret Newman of the Vanderbilt Office of Medical Alumni and Development Affairs.

VISITING ESSAYISTS



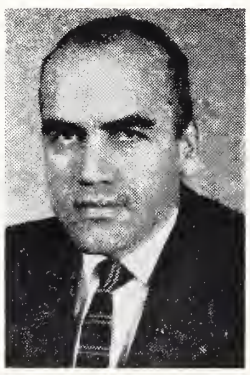
DR. BORNEMEIER

WALTER C. BORNEMEIER, M.D., Chicago. President, American Medical Association. Medical Education, Northwestern University, 1929. Diplomate, American Board of Surgery.



DR. GLASSCOCK

MICHAEL E. GLASSCOCK, III, M.D., Nashville. Clinical Assistant Professor of Surgery, Vanderbilt University. Medical Education, University of Tennessee, 1958. Diplomate, American Board of Otolaryngology.



DR. HIATT

ROGER L. HIATT, M.D., Memphis. Professor and Chairman of Ophthalmology, University of Tennessee. Medical Education, University of Tennessee, 1958. Diplomate, American Board of Ophthalmology.

WILEY C. HUTCHINS, M.D., Memphis. Clinical Instructor of Orthopedic Surgery, University of Tennessee. Medical Education, University of Mississippi, 1960. Diplomate, American Board of Orthopedic Surgery.



DR. HUTCHINS



DR. MCGEE

JAMES H. MCGEE, M.D., Atlanta. Regional Representative, Center for Disease Control, U. S. Public Health Service. Medical Education, Louisiana State University, 1954.

RALPH L. NACHMAN, M.D., New York. Associate Professor of Medicine, Cornell University Medical College. Medical Education, Vanderbilt University, 1956. Diplomate, American Board of Internal Medicine.



DR. NACHMAN

VISITING ESSAYISTS



DR. RANDOLPH

JUDSON G. RANDOLPH, M.D., Washington, D. C. Surgeon-in-Chief, Children's Hospital of the District of Columbia and Professor of Surgery, George Washington University. Medical Education, Vanderbilt University, 1953. Diplomate, American Board of Surgery.

FRANK A. RIDDICK, JR., M.D., New Orleans. Assistant Professor of Clinical Medicine, Tulane University. Medical Education, Vanderbilt University, 1954. Diplomate, American Board of Internal Medicine.



DR. RIDDICK



DR. WEBB

WATTS R. WEBB, M.D., Syracuse, New York. Professor and Chairman of Surgery, State University of New York. Medical Education, Johns Hopkins University, 1945. Diplomate, American Board of Surgery.

WOMAN'S AUXILIARY TO THE MISSISSIPPI STATE MEDICAL ASSOCIATION

48th Annual Session
The Sheraton-Biloxi
May 3-4, 1971



MRS. CAINE

OFFICERS

MRS. CURTIS W. CAINE
Jackson, President

MRS. T. E. ROSS, III
Hattiesburg, President-elect

MRS. JOE D. HERRINGTON
Natchez, Secretary

MRS. DAVID B. WILSON
Jackson, Treasurer



MRS. ROSS

ANNUAL SESSION CHAIRMEN

MRS. MAL S. RIDDELL, JR.
Winona
General Chairman

MRS. J. GORDON DEES
Jackson
Luncheon

MRS. STEVE SEKUL
Biloxi
Registration

MRS. JOHN M. MCRAE, JR.
Laurel
Publicity

AUXILIARY

Monday, May 3, 1971

9:00 a.m. Registration and Hospitality Coffee, West Lobby, Second Level

4:00 p.m. Finance Committee, Directors Room, Main Lobby Arcade

Tuesday, May 4, 1971

8:00 a.m. Registration and Hospitality Coffee, West Lobby, Second Level

8:00 a.m. Preconvention Board of Directors, Continental Breakfast Meeting, Top of the Sheraton

9:30 a.m. General Session, Gulf Room A, Second Level
Invocation
Welcome
Response
Introductions
Greetings
Paul B. Brumby, M.D., Lexington
President, MSMA
Arthur E. Brown, M.D., Columbus
President-elect, MSMA
Mrs. Virgil Ray Forester, Oklahoma City
AMA Auxiliary Representative
Mrs. Ramsay H. Moore, Dallas
Southern Medical Auxiliary President
Minutes
Treasurer's Report
Roll Call
Presidents' Reports
Chairmen's Reports
Officers' Reports
Memorial Service
Mrs. James R. Stingily, Hazlehurst
Election and Installation of Officers
Adjournment

1:00 p.m. Luncheon, Top of the Sheraton, Central Medical Auxiliary, Hostesses
Invocation
Introduction of Guests
Guest Speaker
Arne E. Larson, Chicago
Director, Department of Medicine and Religion
American Medical Association

4:00 p.m. Postconvention Board of Directors, Biloxi Room, Main Lobby Arcade

Wednesday, May 5, 1971

8:30 a.m. Past Presidents' Breakfast, Biloxi Room, Main Lobby Arcade

MISSISSIPPI ASSOCIATION OF PATHOLOGISTS

The Sheraton-Biloxi
May 2-3, 1971

Carl G. Evers, Jackson, President
Roland F. Samson, Jackson, Secretary

Sunday, May 2, 1971

1:00 p.m. Executive Committee Meeting, Biloxi Room (main lobby arcade)
2:00 p.m. Business Meeting, Biloxi Room
7:00 p.m. Cocktail Party, Gulf Room A (second level)

Monday, May 3, 1971

9:00 a.m. Scientific Session, Gulf Room C (second level)
12:00 noon Adjournment

AMERICAN COLLEGE OF SURGEONS, MISSISSIPPI CHAPTER

The Sheraton-Biloxi
Tuesday, May 4, 1971

Dawson B. Conerly, Jr., Hattiesburg, President
W. Coupery Shands, Jackson, President-elect
Albert L. Meena, Jackson, Secretary-Treasurer

9:00 a.m. Scientific Program, Gulf Room B, Second Level
Open to all members of MSMA
Immediate Care of Surgical Emergencies in the Newborn
Judson G. Randolph, Washington

9:45 a.m. Surgery for Coronary Artery Disease
Watts R. Webb, Syracuse

10:30 a.m. Subcutaneous Mastectomy and Augmentation for Recurrent Breast Nodules
James H. Hendrix, Jackson

11:15 a.m. Problem Cases in Surgery
Jerry R. Adkins, Biloxi
H. Vann Craig, Natchez

12:00 noon Business Meeting

12:30 p.m. Luncheon, Gulf Room C, Second Level, Members and Guests

His makeup is unique by tradition.
His ulcer treatment is unique by tradition, too.

In the world of entertainment, a clown's makeup remains the exclusive property of its originator. Time has established that tradition. In the treatment of ulcers and other gastrointestinal complaints, time has established Pro-Banthine as a tradition too.

Few drugs can boast a longer successful run. Introduced 17 years ago, this drug is a veteran gastrointestinal performer.

Pro-Banthine stars in the treatment of peptic ulcer, functional gastrointestinal disturbances, ulcerative colitis, hypertrophic gastritis, pylorospasm, acute and chronic pancreatitis, diverticulitis, biliary dyskinesia, hyperhidrosis, ileostomies, and colonic, ureteral or urinary bladder spasm. Its fame as an anticholinergic is worldwide.

When you want a performer you can count on . . . remember Pro-Banthine. Tradition does.

SEARLE Research in the service of medicine.
G. D. Searle & Co., Chicago, Ill. 60680

Pro·Banthine®
(propantheline bromide)
the traditional ulcer treatment



Pro-Banthine 15 mg.
propantheline bromide



Pro-Banthine 15 mg.
propantheline bromide
with
Dartal 5 mg.
thiopropazate
dihydrochloride



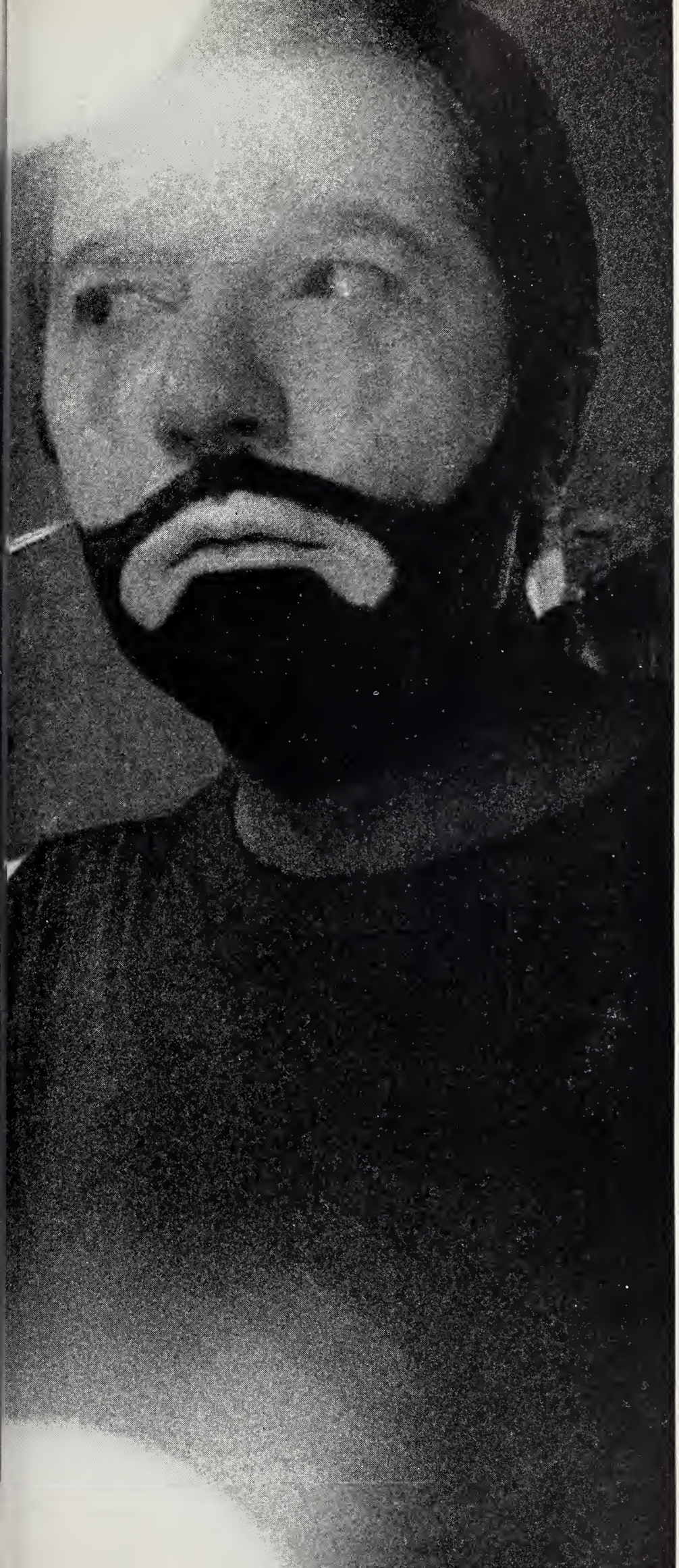
Pro-Banthine 15 mg.
propantheline bromide
with
Phenobarbital 15 mg.
warning:
may be habit forming



Pro-Banthine P.A. 30 mg.
propantheline bromide
in time-release form



Pro-Banthine 7½ mg.
propantheline bromide
Half Strength



Pro-Banthine®
(propantheline bromide)

Indications: Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

Pro-Banthine® 15 mg.
(propantheline bromide)
with
Dartal® 5 mg.
(thiopropazate dihydrochloride)

Indications: Peptic ulcer, spastic constipation, nonspecific gastritis, functional gastrointestinal disorders, pylorospasm, hyperhidrosis, irritable bowel syndrome, mucous or ulcerative colitis, functional diarrhea.

Contraindications: Glaucoma, severe cardiac disease.

Warnings: Pro-Banthine with Dartal should not be administered to patients who are under the influence of barbiturates, alcohol or narcotics. The drug should be administered cautiously to epileptic patients or those in depressed states, patients with liver disease and to pregnant women. Hypersensitivity to Dartal may occur rarely in patients with known sensitivity to similar drugs.

Side Effects: Dryness of the mouth, mydriasis, hesitancy of urination; less commonly extrapyramidal (restlessness, dystonia and signs of pseudoparkinsonism such as muscular rigidity, fixed facies, tremor, ataxia, festinant gait and drooling), parasympatholytic (blurred vision, xerostomia, hypotension, nasal congestion and constipation) and curare-like (loss of control of voluntary muscles, particularly the muscles of respiration) reactions. Rarely, leukopenia or allergic purpura. A generalized erythematous skin reaction may occur. Side effects characteristic of phenothiazines such as grand mal convulsions, altered cerebrospinal proteins, cerebral edema, potentiation of the effects of atropine, heat or phosphorus insecticides, autonomic reactions, endocrine disturbances, reversed epinephrine effect, hyperpyrexia or pigmentary retinopathy may theoretically occur but have not been reported with Dartal. Severe hypotension following recommended doses occurs more commonly in patients who are also afflicted by other medical disorders such as mitral insufficiency or pheochromocytoma, and particular attention should be paid to such a possibility although this has not been observed with Dartal.

Adult Dosage: One tablet three times a day.

Pro-Banthine® 15 mg.
(propantheline bromide)
with
Phenobarbital 15 mg.

Warning: May be habit-forming.

For *Indications, Contraindications, Precautions, Side Effects* and *Dosage* see Pro-Banthine. In addition, phenobarbital should be administered with caution to patients with liver disease, mental disturbances or a significant degree of hypoxia.

Pro-Banthine P.A.®
prolonged acting brand of propantheline bromide

For *Indications, Contraindications, Precautions* and *Side Effects* see Pro-Banthine.

Dosage Form: Capsule-shaped, compression-coated, peach tablets of 30 mg. for oral use.

Dosage: The recommended initial dosage is one tablet in the morning and one at night.

084

SEARLE

Research in the service of medicine.
G. D. Searle & Co., Chicago, Ill. 60680

MISSISSIPPI RADIOLOGICAL SOCIETY

Members of the Mississippi Radiological Society will meet on Sunday, May 2, at the Broadwater Beach Hotel, Biloxi, from 2:00 until 5:00 o'clock in the afternoon. The special scientific program features vascular radiology, and an outstanding guest essayist will appear. Officers of the society are Drs. James B. Barlow of Jackson, president, and Nancy W. Burrow of Brandon, secretary.

MISSISSIPPI SOCIETY OF ANESTHESIOLOGISTS

The Mississippi Society of Anesthesiologists will meet at the Country Club of Jackson (Jackson, Miss.) on Sunday evening, May 2, at 6:00 p.m. The guest essayist will be Dr. William S. Howland of New York City, chairman of the Department of Anesthesia, Memorial Center for Cancer and Allied Diseases. Society officers are Drs. James F. Savage, president; Barry B. Aden, president-elect; and Carlos S. Patino, secretary, all of Jackson.

REFERENCE COMMITTEE BREAKFAST

Members of all Reference Committees of the House of Delegates will meet for breakfast on Monday morning, May 3, in Gulf Room D (second level) at 7:00 a.m. Hosts are Drs. William E. Lotterhos of Jackson, speaker, and John B. Howell, Jr., of Canton, vice speaker. At this important meeting, committee members will be instructed in their duties and conduct of hearings later in the day.

MISSISSIPPI ORTHOPAEDIC SOCIETY

The Mississippi Orthopaedic Society will conduct a scientific and business meeting beginning with lunch on Monday, May 3, in Gulf Room D, Sheraton-Biloxi (second level), at 12:00 noon. The meeting is open to members, prospective members, and orthopaedic residents. Members, ladies, and guests will enjoy a cocktail party in the Biloxi Room (main lobby arcade) at 6:00 p.m. Officers are Drs. Daniel J. Enger of Pascagoula, president; J. Elmer Nix of Jackson, president-elect; and Magruder S. Corban of Gulfport, secretary.

MISSISSIPPI UROLOGICAL SOCIETY

Members of the Mississippi Urological Society will meet Monday, May 3, in the Boston Room (main lobby arcade) of the Sheraton-Biloxi, for a luncheon at 12:30 p.m. There will be a business meeting and the Pyelogram Hour. Society officers are Drs. William J. Slaughter of Meridian, president; Charles D. Scruggs of Jackson, president-elect; and W. H. Merrell, Jr., of Jackson, secretary.

FIFTY YEAR CLUB

The Board of Trustees, sponsors of the association's Fifty Year Club, will honor the half-century plus members at a special luncheon on Tuesday, May 4, in the Boston Room (main lobby arcade) at 12:00 o'clock noon. Dr. Mal S. Riddell, Jr., of Winona, chairman of the Board of Trustees, will preside. Mrs. Barbara Shelton, director of the Department of Administrative Services at the executive office, is club secretary.

MISSISSIPPI OB-GYN SOCIETY

The Mississippi Ob-Gyn Society will conduct a luncheon following adjournment of the section on Tuesday, May 4, in Gulf Room D (second level) at 12:00 o'clock noon. Officers of the society are Drs. William R. Raulston of Hattiesburg, president; Charles M. Head of Jackson, president-elect; George Ball of Jackson, secretary-treasurer; and William S. Cook of Jackson, meeting chairman.

MSMA PAST PRESIDENTS' BREAKFAST

Past Presidents of the Mississippi State Medical Association will enjoy a breakfast meeting on Wednesday morning, May 5, in the Boston Room (main lobby arcade) at 7:30 a.m. Dr. James L. Royals of Jackson is host.

AUXILIARY PAST PRESIDENTS' BREAKFAST

Past Presidents of the Woman's Auxiliary to the Mississippi State Medical Association will enjoy a breakfast meeting on Wednesday morning, May 5, in the Biloxi Room (main lobby arcade) at 8:30 a.m. Mrs. Louis C. Lehmann of Natchez is hostess.

MISSISSIPPI ACADEMY OF GENERAL PRACTICE

The Mississippi Academy of General Practice will sponsor a luncheon at 12:00 o'clock noon on Wednesday, May 5, in the Top of the Sheraton. The special guest speaker will be Dr. Rafael C. Sanchez of New Orleans, director of the Division of Continuing Medical Education, the Louisiana State University Medical Center. Officers of the Mississippi Academy are Drs. William H. Parker of Heidelberg, president; James O. Stephens of Magee, president-elect; William B. Hunt of Grenada, secretary; and Miss Louise Lacey of Jackson, executive secretary.

MISSISSIPPI SOCIETY OF INTERNAL MEDICINE

A luncheon meeting of the Mississippi Society of Internal Medicine will be conducted on Wednesday, May 5, in the Boston Room (main lobby arcade), at 12:00 o'clock noon. There will be a brief business session. Officers of the society are Drs. William C. Kellum of Tupelo, president; G. Spencer Barnes of Columbus, president-elect; and S. H. McDonnieal, Jr., of Jackson, secretary.

GOLF TOURNAMENT

The annual association golf tournament will be conducted at the Sunkist Country Club on Wednesday, May 5, Dr. A. V. Hays, Gulfport, chairman. The entrance fee will include one green fee ticket and two 19th hole refreshment tickets. Handicaps are not needed, the two flights being divided by age. Tuesday rounds are acceptable for the single round 18-hole play. For further information, communicate with Dr. Hays at the ENT Hospital, 13th and 31st Ave., Gulfport 39501.

MISSISSIPPI EENT ASSOCIATION

The Mississippi Eye, Ear, Nose and Throat Association will conduct a luncheon and business meeting on Thursday, May 6, in Gulf Room D (second level) at 12:00 o'clock noon. Officers of the association are Drs. Chester W. Masterson of Vicksburg, president and program chairman, and Ben McCarty of Jackson, secretary.

ASSOCIATION PARTY

Members of the Mississippi State Medical Association, their ladies, and guests will enjoy a cocktail party on Wednesday evening, May 5, in the Grand Ballroom West at 6:00 p.m. There is no dinner or program, just good fellowship. Tickets will be available at general registration.

LOUISIANA-MISSISSIPPI OPHTHALMOLOGICAL AND OTOLARYNGOLOGICAL SOCIETY

The Sheraton-Biloxi
May 6-8, 1971

C. Hal Cleveland, Gulfport, President
Paul L. Marks, Baton Rouge, President-Elect
Arthur V. Hays, Gulfport, Secretary-Treasurer

Thursday, May 6, 1971

9:00 a.m. Section on Eye, Ear, Nose, and Throat, Mississippi State Medical Association, Gulf Rooms A and B

Friday and Saturday, May 7-8, 1971

Ophthalmology

Arthur Jampolsky, San Francisco
Smith-Kettlewell Institute of Visual Sciences
University of the Pacific

Roderick MacDonald, Jr., Louisville
Professor and Chairman, Department of Ophthalmology
University of Louisville

Otolaryngology

B. R. Alford, Houston
Professor and Chairman, Department of Otolaryngology
Baylor College of Medicine

Roger Boles, Ann Arbor
University of Michigan Medical Center

RECREATION

The Society will sponsor golf and tennis tournaments and a skeet shoot. For the best in deep sea fishing, charter boats will be located in the adjacent Broadwater Beach Marina, immediately west of the Sheraton-Biloxi. There will be an art show for the ladies.

SEAFOOD JAMBOREE

Friday evening, May 7, Fellows, ladies, and guests may enjoy a Famous Biloxi Seafood Jamboree with music by the Dixieland Band.

DINNER DANCE

Saturday evening highlight is a cocktail-dinner dance with music by Rene Louapre's Mardi Gras Ball Orchestra.

REGISTRATION FEES

Fees for registration are $20 for nonmember guests, $10 for ophthalmologists and otolaryngologists in military service, and no charge is made for residents. Registration will open at 4:00 p.m. on Thursday, May 6, 1971. For additional information, communicate with Dr. Arthur V. Hays, Secretary-Treasurer, 3017-13th St., Gulfport, Miss. 39501.


ALLERGIC
TO
PENICILLIN

Handbook of the House of Delegates

Mississippi State Medical Association
103rd Annual Session, Biloxi
May 3-6, 1971

HANDBOOK INFORMATION

The Speaker and Vice Speaker of the House of Delegates herewith present for the information of all members those reports and resolutions as have been received for publication in advance of the 103rd Annual Session. It is the intent of this advance publication to inform the membership and to afford all concerned the opportunity to confer with delegates over any aspect of the reports and resolutions.

No report or resolution herein becomes official or a statement of policy until formally presented to the House of Delegates and acted upon at the annual session.

WILLIAM E. LOTTERHOS
SPEAKER

JOHN B. HOWELL, JR.
VICE SPEAKER

SUPPLEMENTAL REPORT A OF THE SECRETARY-TREASURER

Vacancies in Elected Offices. Effective May 6, 1971, there will occur 24 vacancies in elected offices in the association by reason of expiration of prescribed terms of service. Additionally, the House of Delegates must nominate three members for each of three posts on the Mississippi State Board of Health. In accordance with the By-Laws, the Nominating Committee will be asked to deliberate, consult with colleagues, and make nominations to the House of Delegates for consideration and voting to elect successors or to re-elect incumbents.

Eligibility. To be nominated for office in the association, a nominee must have been a member for two years, be in present good standing as a member, and must have attended two of the past three annual sessions, including the present one. A member may not serve more than three consecutive terms as a member of the Board of Trustees or a council. Incumbents ineligible for re-election for this reason are indicated in the listing of offices to be filled.

Vacancies for Nomination. Following is the listing of vacancies which will occur during the 103rd Annual Session as well as requirements for nominations and identity of incumbents:

President-elect

Nominate three, no two of whom may be from the same county, elect one.

Vice Presidents

Nominate three for the Northern Area, three for the Mid-State Area, and three for the Southern Area. Elect one for each area.

Delegate to AMA

Term Jan. 1, 1972-Dec. 31, 1973. Nominate two, elect one. Incumbent: G. Swink Hicks, Natchez.

Alternate Delegate to AMA

Term Jan. 1, 1972-Dec. 31, 1973. Nominate

two, elect one. Incumbent: Joseph B. Rogers, Oxford.

Associate Editor

Term 1971-72. Nominate two, elect one. Incumbent: Thomas W. Wesson, Tupelo.

Board of Trustees, Districts 4, 5, and 6

Terms 1971-74. Nominate two for each district, elect one for each district. Incumbents: Mal S. Riddell, Jr., Winona, District 4, who is not eligible for re-election; William O. Barnett, Jackson, District 5; and Guy T. Vise, Meridian, District 6.

Council on Budget and Finance

At the 102nd Annual Session, the By-Laws were amended to expand this council to five from three members. It will be necessary to elect three members, one for a regular term of three years, one for a term of two years, and one for a term of one year, to achieve the rotation of terms required in the By-Laws.

Term 1971-75. Nominate two, elect one. Incumbent: J. T. Davis, Corinth, who is not eligible for re-election.

Term 1971-73. Nominate two, elect one. New post.

Term 1971-72. Nominate two, elect one. New post.

Council on Constitution and By-Laws

Term 1971-74. Nominate two, elect one. Incumbent: Raymond S. Martin, Jr., Jackson.

Judicial Council, Districts 1, 2, and 3

Terms 1971-74. Nominate two for each district, elect one for each district. Incumbents: Frank M. Acree, Greenville, District 1; Rhea L. Wyatt, Holly Springs, District 2, who is not eligible for re-election; and Arthur E. Brown, Columbus, District 3.

Council on Legislation, Districts 1, 2, and 3

Terms 1971-74. Nominate two for each district, elect one for each district. Incumbents: John G. Egger, Drew, District, 1, who is not eligible for re-election; James L. Thornton, New Albany, District 2; and Frank M. Davis, Corinth, District 3, who is not eligible for re-election.

Council on Medical Education

Term 1971-74. Nominate two, elect one. Incumbent: William O. Barnett, Jackson, who is not eligible for re-election.

Council on Medical Service, Districts 4, 5, and 6

Terms 1971-74. Nominate two for each district, elect one for each district. Incumbents: Paul B. Brumby, Lexington, District 4; John G. Caden, Jackson, District 5; and William M. Gillespie, Jr., Meridian, District 6.

Mississippi State Board of Health, Public Health District 6

Counties of Simpson, Lawrence, Jeff Davis, Covington, Jones, Wayne, Marion, Lamar, Forrest, Perry, Greene, Pearl River, Stone, George, Hancock, Harrison, and Jackson. Term Jan. 1, 1972-Dec. 31, 1977. Nominate six, vote for three. Incumbent: Joseph G. McKinnon, Hattiesburg.

Mississippi State Board of Health, Public Health District 7

Counties of Claiborne, Copiah, Jefferson, Lincoln, Adams, Franklin, Wilkinson, Amite, Pike, and Walthall. Term Jan. 1, 1972-Dec. 31, 1977. Nominate six, vote for three. Incumbent: G. Swink Hicks, Natchez.

Mississippi State Board of Health, Public Health District 8

Counties of Warren, Hinds, Rankin, Yazoo, and Madison. Term Jan. 1, 1972-Dec. 31, 1977. Nominate six, vote for three. Incumbent: H. C. Ricks, Sr., Jackson.

REPORT OF THE DELEGATES TO AMA

Your delegates to the American Medical Association, in conformity with custom and past practices, have limited their joint report to this House of Delegates to key policy actions at the annual and clinical conventions. Because of the comprehensive reporting in the *American Medical News* and *Journal AMA* of scientific and subsidiary activities, further reporting of these aspects of the AMA conventions would constitute needless duplication and repetition.

Dr. G. Swink Hicks of Natchez entered upon his second full term Jan. 1, 1970. Following the resignation of Dr. Howard A. Nelson of Greenwood in May 1970, President Brumby appointed Dr. Stanley A. Hill of Corinth to serve the unexpired term. Dr. Hill was seated at the Chicago annual and Boston clinical conventions. To serve Dr. Hill's unexpired term as alternate delegate, President Brumby appointed Dr. C. D. Taylor, Jr., of Pass Christian. Dr. Taylor, elected delegate to AMA at the 102nd Annual Session, entered upon his first term on Jan. 1, 1971. Dr. Hill, re-elected alternate delegate, has entered upon his new term of service. Dr. Joseph B. Rogers of Oxford continues to serve as Dr. Hicks' alternate.

This reporting covers the 119th Annual Convention at Chicago, June 21-25, 1970, and the 24th Clinical Convention at Boston, Nov. 29-Dec. 2, 1970. Your delegation is indebted to our president and other officers and members who participated in these conventions and worked with us.

When, on the final day of the Boston clinical convention, it was necessary for Dr. Hicks to return to Mississippi for an important meeting of the State Board of Health, Dr. S. Jay McDuffie of Nettleton, was certified and seated as substitute delegate, as provided for in the AMA By-Laws.

Chicago Annual Convention. The House of Delegates considered 201 items of business during more than 17 hours of meetings, not including time spent in reference committee hearings. The Board of Trustees submitted 31 reports, and there were 30 others from various councils and committees. A total of 140 resolutions were introduced, including 27 relating to the Report of the Committee on Planning and Development (Himler Report).

Among all issues considered, none was more sharply debated than the now-well-known policy position on abortion:

"Resolved, That abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only in conformance with standards of good medical practice, and after consultation with two other physicians chosen because of their professional competence, and within the Medical Practice Act of his state; and be it further

"Resolved, That no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

Prior to the Chicago convention, wide publicity had been given a dues increase decided upon by the Board of Trustees. The proposal was an increase to $150 per year from $70. The House voted an increase to $110 per year, and removed from the authority of the Board the dues-fixing prerogative by amendment of the By-Laws. Unlike our state medical association where the House of Delegates has always possessed the dues-setting authorities, the AMA By-Laws previously permitted the Board to do this, thus requiring the House to accept or reject the decision.

Most state association delegations had instructions on the controversial Himler Report, and 27 resolutions were introduced in connection with it. The matter was, in effect, put to rest by three actions: Creation of a standing body of the House of Delegates designated the Council on Long-Range Planning and Development, extensive revision (and in many instances, deletion) of the controversial recommendations, and recommital of the report to the new body. This has resulted in the Himler Report having been removed from implementation and requires that any further matter within or arising from it be submitted to the House of Delegates by the new council of the House.

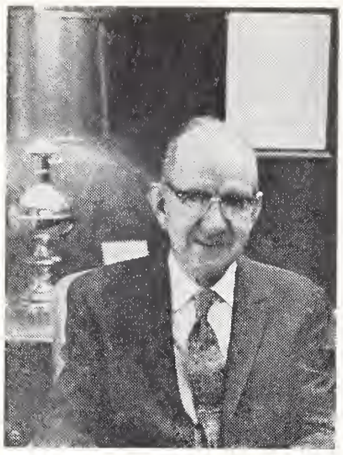
The concept and format of formal postgraduate medical education were altered by what amounts to elimination of the internship. The action requires that no new internship program be approved after July 1, 1971, unless it and a related residency are organized and conducted as a unified and coordinated whole. From and after July 1, 1975, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education.

Professional liability insurance, a critical matter in at least half of the states, especially in the west, was the subject of special reports and resolutions. The Board reported that it was exploring the possibility of instituting a joint AMA-state medical association program which would be optional with states.

Allied professional personnel, particularly nurses, were considered as well as their respective definitive roles in patient care, training, and postgraduate or continuing education. A number of separate but related actions were taken on hospitals as regards the requirement of the Joint Commission on Accreditation of Hospitals as to records-keeping and staff privileges and responsibilities. The House reaffirmed the AMA position that general practitioners should have the opportunity to practice medicine as active staff members in hospitals and should be granted privileges commensurate with their training and demonstrated abilities. It was also recommended that medical staffs consider revising their respective hospital medical constitutions and by-laws to differentiate clearly between medical and administrative duties.

The House approved a Board proposal to establish a wholly owned separate subsidiary corporation to engage in publication and possibly other related activities for purposes of economy. Approval was given to a communications program which would consist of television documentaries, educational advertising, media relations, and other activities to improve public understanding and opinion of the profession. The cult of chiropractic was again condemned, and the Judicial Council ruled that it is not unethical for a

(Turn to page 222)



The President Speaking

'The Case for Foundations'

PAUL B. BRUMBY, M.D.
Lexington, Mississippi

WE SEE ALMOST daily some new or different approach being recommended to Congress as the proper method of restructuring health care and its delivery. However, during the past few days, Wilbur Mills declared that the present Social Security measures before Congress with the Bennett amendment or some compromised version of this bill will be enacted before any new health measures will be completed. He did intimate that some national health care system is probably sure of future enactment. With the enactment of the Bennett amendment, it will be demanded that physicians or some other agency police the cost, the quantity and the quality of medical care. Within a few months, this task will be ours. Few societies have reported their local review panels, although our state committee will be prepared to place in the hands of each physician a booklet outlining norms of medical practice. There will be many necessary deviations from these guidelines which will throw decision-making into the hands of our local review panels.

Medical foundations established by medical societies either locally or at the state level are gaining popularity. There are more than 20 such foundations at present. Iowa and Georgia have recently established this mechanism to guarantee the quality and quantity of health care and full acceptance of cost of physician services. These foundations are directed by physicians and their own selected employees and panels. They will be honest brokers between the individual physicians and third party entities.

The AMA will furnish an in-depth study of medical care foundations at a national meeting within months and we from Mississippi will have a chance to learn much more about their implementation. Even Senator Kennedy, with his labor-backed attempt to completely socialize medicine, suggests that these medical care foundations might be instruments which he could use. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 4

APRIL 1971

EDITORIALS

Infant Mortality Data: International Shell Game

I

SECOND ONLY TO CHIROPRACTIC, the biostatistical ball game on infant mortality is the international health hoax of the century. The rules for comparing infant mortality nation-by-nation are about as valid as permitting the home team catcher to call the fouls on the visiting hitters. It is a shell game which its sponsor-umpire, the United Nations, paradoxically disclaims and condones at the same time. And the more honest the player, the greater the odds are against him.

The needless death of a helpless baby is a tragic, repugnant thing, properly evoking emotions of anger, frustration, and disgust. American medicine has devoted some of its best efforts to fetal salvage and prevention of infant mortality. Playing the game fair and square with tough groundrules has not, however, gained the American health team a high standing in the league, because the other teams make up their own rules where an infield grounder is worth two bases and a fly foul right is a home run.

So prevalent has this practice become that Dr. Walter C. Bornemeier of Chicago, president of the American Medical Association, recently called a press conference to set the record straight. He did, but it won't be, because this statistical prestidigitation has been going on for years. The JOURNAL has the scars to prove it, too, when Dr. David D. Rutstein of the Harvard Medical School took us to task in 1964 over the same issue. The subject is a darling of the detractors of health care in America, including CBS, proponents of all sorts of national health schemes, and assorted others who simply do not like health care delivery in its present American configuration.

There ought to be a law . . . and there are, too. About as many different ones as there are nations keeping score on infant mortality. Except that the game is crooked, and the cards are stacked.

II

The dean of American biostatisticians, Dr. Donald Mainland of New York University Medical Center, warns that "death rates classified by region depend on the rules, sometimes local rules, observed in tabulation." And then addressing himself to bias in such tabulations, he says that "causation in medicine is like an iceberg, mostly hidden from view, but we often behave as if what we can see is all that matters, and we disregard the submerged mass that may wreck our causal inferences."

Dr. Bornemeier stressed that record-keeping criteria vary so widely throughout the world that even among highly developed nations there is no real basis for comparison.

Citing as an example the definition of a live birth in the United States, the AMA president

explained that it means *any sign of life.* This means a heart beat, movement of voluntary muscles, a breath, or even a pulsation of the umbilical cord. But in some nations, conveniently defined in law, a birth—and hence, an infant death —is not recorded if the baby does not breathe or in some instances, if the child dies before the birth is registered some days later. Some examples are pertinent and illuminating:

—The Netherlands does not list as infant deaths babies who die before registration of birth. This is often as long as a week, so a baby who dies on the third day of life is listed as a stillbirth.

—Until 1960, Sweden recognized only the act of breathing as a valid sign of life. Other quickening signs were legally disregarded, and the ensuing death, under these criteria, didn't go on the infant mortality scoreboard.

—Infants weighing less than 800 gm are not even included in stillborn statistics in Finland.

—The United Kingdom has its own system, too: Data are tabulated by year of occurrence for England and Wales and by year of registration for North Ireland and Scotland. Births before 28 weeks gestation are recorded as stillbirths.

—In Ireland, data on events are registered within one year of occurrence, and the data are tabulated by the year of registration rather than the year of occurrence.

Infants born alive who die before registration are recorded as stillbirths in Belgium, France, Algeria, Mauritius, Morocco, Réunion, Guadeloupe, Martinique, St. Pierre, and Miquelon.

In five jurisdictions, Spain, Ceuta, Melilla, Ecuador, and Cuba, the law specifies that an infant must survive at least 24 hours to acquire civil rights, and registration of a live birth cannot legally take place until after expiration of this period. If, in these jurisdictions, a live infant dies in the first full day of life, it is recorded as *abortos.*

III

But even if there were no such ludicrous birth registration laws, just how valid is this biostatistical ball score on the efficacy of any health care system? It is fashionable to make comparisons in an international context, the nation-against-nation frame of reference, and Sweden leads the league for assured life. But this is based on inadequate data and faulty conclusions, more frequently than not couched in emotion. Consider these four points:

First, infant mortality is not the best or even a good indicator of the status of health in a nation. It is, for the greater part, *a social rather than a medical problem,* even if it were measured on a uniform yardstick around the world. Factors such as economics, nutrition, housing, education, and racial or ethnic differences are much more logically correlated with infant mortality than the supply of physicians and number of hospital beds.

Second, there are alternative yardsticks, not necessarily unto themselves the best indicators of health status, which are much better than infant mortality. According to the *Report of the President's Commission on Health Needs of the Nation,* 70 per cent of all U. S. deaths are related to heart disease, cancer, or stroke. Infant mortality, even by our tough, honest American criteria, accounts for just 2.2 per cent of all U. S. deaths. While nobody is complacent about babies dying, the data on infant mortality do not deserve the attention they receive.

Third, if it makes little sense to employ infant mortality as a health status indicator, then it makes even less sense to use it as the basis for international ranking of health status among nations. Dr. Mainland has warned us about the



"Are you sure that goes here?"

statistical shell game, and the implications suggested by such comparison—later sworn to as fact—are invalid.

Let's take this business of comparing health in Sweden and the United States: The U. S. has 205 million population, and Sweden has 8 million. We have 3.6 million square miles, while Sweden is about the size of California. Our population is extremely heterogeneous measured by anybody's criteria, but Sweden is about as homogeneous in population as you can get.

Given the constant that Sweden and the United States are about at the same point in medical knowledge, which might be expected to have the lower infant mortality rate? Since part of Sweden is in the Arctic Circle, how many babies are killed there in auto accidents each year?

And when the inference is made that the U. S. should accordingly adopt the Swedish system of socialized medicine in the interest of lower infant mortality, it is as if to conclude that Jackson ought to adopt the same type of public transportation system as found in Corinth, since traffic congestion is much less in Corinth than in Jackson.

Fourth, it appears that infant mortality data in the hands of the health Houdini's are being employed to prove a point. For example, the UN data can be used to prove that:

—Sweden has the best health care system because it has the lowest infant mortality rate.

—The Netherlands has the best health care system because it has the lowest death rate due to tuberculosis and pneumonia.

—France has the best health care system because it has the lowest mortality from stomach ulcer.

—The United States has the best health care system because it has the lowest death rate from bronchitis.

IV

The United Nations compiles these data through the World Health Organization. When they are published each year, the *Demographic Yearbook* invariably carries the disclaimers: "Despite the fact that the obtaining of live birth, death, foetal death, marriage, and divorce statistics has been given priority in the United Nations recommendations, the availability of such statistics varies widely. This is due in part to lack of uniformity and universality in national legislation."

After this euphemism, the *Yearbook* continues: "The need for distinguishing between statistics for areas or populations where registration is moderately complete and those in which it is incomplete has been recognized. . . ." Then it goes on to say that in Surinam, the data for the tribal population has been excluded. In Peru and Venezuela, the birth and death data omit the Indian tribes. Australia formerly excluded data on the aborigines, and nobody really knows how valid it is today.

Now, nobody is so naïve as to believe that all of the UN member nations will sit down at the next General Assembly and adopt the U. S. groundrules for reporting infant mortality. But we do have every reason to expect and demand that those occupying high positions of responsibility in government, the sciences, and the news media get their signals straight and adopt a modicum of probity in their hitherto reckless use of incomparable data.

Some wags have suggested that the U. S. keep two sets of books in vital statistics: One which is honest, as is now done, and one which uses the criteria of other nations for use by those who simply must draw conclusions from international comparison. A more serious suggestion is for hearings by the Congress to see if the executive agencies of government need to be made a little more honest in use of these data and in presenting them in true context of extranational definition.—R.B.K.

Some Physician Responsibilities in Workmen's Compensation

Lynn D. Abernethy, M.D.
Jackson, Mississippi

HAVING ACCEPTED the responsibility of caring for a patient covered under Workmen's Compensation, it goes without saying that the physician should secure for him or her every needed reasonable form of treatment available in the area and extend the same degree of devotion and skill as he would do in all other similar diseases or injuries. It is apparent that once a doctor-patient relationship has been established, it is the physician's further responsibility to render necessary reports required by law to the employer and/or his insurance carrier and to do this within a reasonable time. The writer has found that a simple check-off form supplying such information as to the nature of the case, that is, whether industrial or nonindustrial, whether hospitalized, date of return suggested, ability to work, discharge date, etc., given to the employee for delivery to the employer at the time of the first visit

appears to supply a need for the employer and it also helps quiet the physician's phone.

The physician's responsibility encompasses securing rehabilitation through utilization of his own skills and those of his colleagues and extends to having a knowledge of the private and governmental agencies available and a willingness to utilize these services when appropriate.

When the opportunity arises, the physician alone or in concert with his colleagues, has an obligation to point out inequities in the statute of a purely medical character and to aid in the correction thereof. It is manifestly not the physician's responsibility to suggest in monetary terms the value of any defect arising out of any occupational injury or disease. It is well within his province, however, to assist in the securing of equal compensation for the same type of loss of function or organ in the various states.

Since the physician's assessment of disability is the primary basis on which compensation is allocated, it is therefore every physician's responsibility to strive for accurate assessment of disability to the end that justice is served and confidence in the medical profession promoted. To achieve this, a recognized uniform method of evaluating disability applicable to the type of occupational disease or injury concerned, should be practiced so that disability evaluations submitted by different physicians are reasonably close so that when transposed into a monetary award no great discrepancy will exist. When there is a wide discrepancy evidenced in Form B-27 many people can see that medicine is not an exact science, or suspect it of not being a science at all and thus encourages litigation as a result of which the employee has to divide his just monetary compensation with an attorney or attorneys. ★★★

653 North State Street (39201)

Ophthalmology Member, Committee on Occupational Health, Mississippi State Medical Association.

Baseball, Bowie Kuhn, and (No) Drug Abuse

Hats off to Commissioner Bowie Kuhn, boss of major league baseball, and to the team physicians who have initiated a new and constructive health program unique in professional sports. Beginning last month in the spring training camps, players will receive mandatory instruction through a series of seminars on the danger of drug abuse.

The commissioner says that the program isn't a one-shot deal but a continuing educational effort which will be with the majors from here on in.

"We are not naïve about the threat of drugs, the nature of the problem, or the fact that in baseball there has been some use of pills in the amphetamine and barbiturate groups," Commissioner Kuhn said. In announcing the seminars for all 24 clubs, he also said that baseball has been fairly free and clean of drug abuse and that it intends to get even better and stay that way.

Not only is the seminar instruction mandatory but there also have been set up mechanisms for disciplinary action where a player is found abusing drugs. The program was the brainchild of the major league team physicians who called on Dr. Garrett O'Connor of Baltimore, director of the Johns Hopkins Drug Abuse Center, to guide the formation of the program.

Initial meetings were begun in early March with organization of the seminar series. The presidents of the American and National leagues, Joe Cronin and Chub Feeney, are hearty advocates of the program which will be carried down into the minors. Not only is the health of the player a major consideration but the reputation of baseball as a respected team sport is also important.

This is one of the best developments in professional sports since every team got a physician and made health considerations part of the game. The state medical association salutes the commissioner for his exercise of leadership and for making the national pastime a better institution than ever before.—R.B.K.



"And now, Dr. Finley will give us his closing remarks."

1971 and the Art of the Possible

Within hours, the 1971 Regular Session of the Mississippi Legislature will be history. In broad and general terms, this has been one of the best sessions in a decade for constructive actions in the health and medical field. Nor has this been a happy coincidence or inadvertent good fortune, either.

First, the legislative climate in 1971 was 180° off 1970. Senators and representatives worked in harmony, so much so that the Associated Press ribbed them for being too calm and generating little oratory which might be useful in campaigns for re-election. There was a businesslike atmosphere in the Capitol during the past three months, and in contrast to last year, tempers of the solons were even and the blood pressure, much lower.

But the Mississippi State Medical Association and its 1,450 members tried harder, too. The House of Delegates approved an expanded legislative program and financed it, after the near-fiasco of 1970. Provision was made for weekly publication of the *Mississippi Medical Legislative Report*, popularly called the "Blue Sheet" by many physicians. For the first time, we enjoyed regular and detailed communication to every member on virtually every bill of health and medical interest.

Then there was intensified activity by the Council on Legislation, meeting frequently, communicating almost incessantly, and getting together with key leaders and committees of the House and Senate.

The Emergency Medical Care Unit was staffed and manned with heretofore unknown success. Where we had been fortunate to have a Doctor-of-the-Day half of the time last year, we had only six blanks in the 90-day session.

Provision was made for sufficient staff in the executive office at Jackson to have daily representation by one—and usually two—of the staff executives. The contacts were continual, and close liaison was maintained with committee chairmen. Testimony was presented by physicians on a number of occasions, and written statements, letters, and position papers flowed regularly into the hands of the Legislature from the state medical association.

All of this is not to say that the program attained its full objectives or that we have all of the secrets of the totally successful legislative program. In fact, some good bills were lost, but not a single major bill opposed by the medical association was passed. At all times, we were courteously received, patiently listened to, and honorably treated.

This takes time, effort, and financing, and the association was willing to devote sufficient resources to get on with the job. Not every member or even most of the members will find complete satisfaction in the program, but almost all can agree that the absence of harsh proposals against medicine and the lack of acrimony made the effort worthwhile.

Legislative programs dip deeply into politics, however nonpartisan and sincerely objective the program sponsors try to be. And politics is the art of the possible where things are sometimes neither black nor white. The solons have a tough job to do, and the 90-day annual session toughens the job up more. We are grateful to many: Those in the House and the Senate, to the staff of the two chambers, to the members of the state medical association who took a minute to speak or write on a bill, and to others who contributed.

It was worth the effort, and think how much more can be done with every physician's giving just a little more time and effort for the health of the citizens of the state and the good of his profession.—R.B.K.

POSTGRADUATE CALENDAR

UNIVERSITY MEDICAL CENTER MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

April 5-9, 1971

PEDIATRICS INTENSIVE COURSE

University Medical Center, Jackson
April 5-9, 1971, beginning at 8 a.m.

Sponsored by The University of Mississippi School of Medicine, with the support of the Mississippi Regional Medical Program

Coordinators:

J. M. Montalvo, M.D., associate professor of pediatrics, The University of Mississippi School of Medicine

Nell J. Ryan, M.D., asociate professor of pediatrics, The University of Mississippi School of Medicine

Offered for the second time this year, the pediatrics one-week intensive course will emphasize scalp vein techniques, use of the res-

pirator, resuscitator, nebulizer and humidifier. Participants will take up common pediatric problems, round, join in group discussions and attend lectures on cardiology, hematology, immunizations, allergies, seizures and pediatric emergencies.

April 19-23, 1971

RADIOLOGY INTENSIVE COURSE

University Medical Center, Jackson
April 19-23, 1971, beginning at 8 a.m.

Sponsored by The University of Mississippi School of Medicine with the support of the Mississippi Regional Medical Program

Coordinator:
Robert D. Sloan, M.D., professor of radiology and chairman of the department, The University of Mississippi School of Medicine

This one-week intensive course, the year's second session, will include practical observations of radiologic procedures in the diagnostic, therapeutic and isotope areas, as well as sessions dealing with equipment, techniques, artefacts and radiation safety.

Both intensive courses are part of the Mississippi Postgraduate Institute in the Medical Sciences, which is supported by the Mississippi Regional Medical Program. Each class is limited to five Mississippi family physicians from the class of 40 enrolled in the Institute.

CIRCUIT COURSES

EASTERN CIRCUIT

Meridian—April 6—Session 2; Briarwood Country Club, 6:30 p.m.
Session 2—Diagnosis and Management of Rheumatoid Arthritis, Dr. T. E. Wilson, III
Mechanisms of Anemia, Dr. Francis Morrison
Columbus—April 27—Session 3; The Downtowner Motor Inn, 6:30 p.m.
Session 3—Goiter in Children, Dr. J. M. Montalvo
Acute Abdominal Conditions in Infants, Dr. Richard Miller

SOUTHWEST CIRCUIT

McComb—April 13—Session 3; Southwest Mississippi General Hospital, 7 p.m.
Natchez—April 20—Session 3; Jefferson Davis Memorial Hospital, 7:30 p.m.
Session 3—Inhalation Therapy, Dr. Walter Treadwell
Inhalation Therapy Equipment as a Reservoir of Infectious Agents, Dr. William Lockwood

FUTURE CALENDAR

April 5-9, 1971

PEDIATRICS INTENSIVE COURSE

April 6

CIRCUIT COURSE, MERIDIAN

April 13

CIRCUIT COURSE, MCCOMB

April 19-23

RADIOLOGY INTENSIVE COURSE

April 20

CIRCUIT COURSE, NATCHEZ

April 27

CIRCUIT COURSE, MCCOMB

May 3-6

MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

May 11

CIRCUIT COURSE, MERIDIAN

PERSONALS

G. SPENCER BARNES of Columbus is currently serving a term as president of the Mississippi Heart Association.

WILLIAM P. FEATHERSTON of Jackson has been appointed medical director for technical supervision of the new Blood Services laboratory branch office in Jackson.

WILLIAM B. GIFFORD of Eupora attended the annual meeting of the Mid-South Medical Association in Memphis.

WILLIAM L. JAQUITH, director of the Mississippi State Hospital at Whitfield, was a guest speaker at the three-day conference for Catholic Youth Organization in Jackson.

EDLEY H. JONES of Vicksburg was guest speaker for the otolaryngology section of the New Orleans Graduate Medical Assembly, March 8-11. Dr.

Jones discussed "External Otitis, 1971," and "Young Children With Ear, Nose and Throat Problems."

DONALD E. KILLELEA of Natchez has been appointed to the board of trustees of Jefferson Davis Memorial Hospital.

RAY LEE of Liberty has opened an office for the general practice of medicine in Tylertown. Dr. Lee shares office space with J. J. PITTMAN every weekday afternoon except Wednesday.

JERRY C. LINGLE announces the opening of his office for the general practice of medicine and surgery at the Family Clinic, 222 South Church Street, Brookhaven.

WILLIAM A. LONG, JR., of Jackson spoke at Hazlehurst Presbyterian Church recently. Dr. Long discussed a view of the adolescent today at the meeting sponsored by the Cherokee Rose Chapter DAR.

JAMES O. MANNING of Jackson has been inducted as a Fellow of the American Academy of Orthopaedic Surgeons.

JAMES R. MAYFIELD of Carthage is the recipient of the Leake County Jaycees Distinguished Service Award for 1970. This is the second time Dr. Mayfield has received this award.

JOHN B. O'KEEFE of Biloxi reigned as king of the Young Matrons' Ball held recently at the Biloxi Community Center.

COLEMAN PICKLE of Kosciusko has been named Attala County's Outstanding Citizen for 1970.

G. BOYD SHAW of Jackson has been appointed medical director of inhalation therapy-pulmonary services at St. Dominic-Jackson Memorial Hospital.

REGINALD P. WHITE of Meridian was appointed by Gov. John Bell Williams to the Commission on Mental Illness and Retardation of the Southern Regional Education Board.

JESSIE WOFFORD of Jackson was guest speaker at a recent meeting of the Central District Nurses' Association. Dr. Wofford discussed emphysema at the gathering held at Baptist Hospital's Gilfoy Auditorium.

HARVEY B. WRIGHT of Laurel announces the relocation of his office to the Laurel Eye Center at 306 South 12th Avenue. Dr. Wright limits his practice to ophthalmology.

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NEW MEMBERS

BALL, DAVID ALFORD, Batesville. Born Columbus, Miss., Sept. 13, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned Lackland Air Force Hospital, San Antonio, Texas, one year; elected Oct. 1, 1970 by North Mississippi Medical Society.

CARTER, DAVID K., Quitman. Born Meridian, Miss., Jan. 7, 1943; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1969; interned University Hospital, Jackson, Miss., one year; elected Feb. 2, 1971 by East Mississippi Medical Society.

HENRY, JOSEPH RAYMOND, New Albany. Born New Albany, Miss., June 3, 1913; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1939; interned Grace Hospital, Detroit, Mich., one year; surgery residency, Brooke General Hospital, Ft. Sam Houston, Texas, Jan. 1, 1947-Dec. 31, 1949; certified by the American Board of Surgery in 1956; elected Oct. 1, 1970 by North Mississippi Medical Society.

HOWARD, ANSE B., III, Louisville. Born Laurel, Miss., Dec. 18, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned Mississippi Baptist Hospital, Jackson, Miss., one year; elected Feb 2, 1971 by East Mississippi Medical Society.

RAYNER, JAMES WHITNEY, Oxford. Born Meridian, Miss., Feb. 16, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned City of Memphis Hospitals, Memphis, Tenn., one year; ophthalmology residency, University of Tennessee, Memphis, Tenn., July 1967-June 1970; elected Oct. 1, 1970 by North Mississippi Medical Society.

DEATHS

BRANTLEY, FRANK LOUIS, Madden. M.D., Memphis Hospital Medical College, Memphis, Tennessee, 1913; postgraduate, Tulane in 1943; member of Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; presented Golden "T" by University of Tennessee in 1963; past president of Leake County Medical Society; died Jan. 31, 1970, age 83.

BRISTER, SAMUEL L., JR., Greenwood. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1926; interned St. Mary's Free Hospital for Children, New York, N. Y., one year; postgraduate work in pediatrics; died Feb. 25, 1971, age 68.

MCILWAIN, ALBERT JEFFERSON, Jackson. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1931; interned Hollywood Clara Barton Memorial Hospital, Los Angeles, Calif., one year; radiology residency, St. Luke's Hospital, Chicago, Ill., 1941; radiology residency, Dallas City Hospital, Dallas, Texas, 1941-1943; Diplomate, American Board of Radiology 1944; died Feb. 15, 1971, age 65.

RIDDELL, TOBE MILLARD, Shaw. M.D., Memphis Hospital Medical College, Memphis, Tennessee, 1911; interned St. Joseph's and City Hospitals, Memphis, Tenn., one year; presented Golden "T" by University of Tennessee in 1961; member of Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; died Feb. 27, 1971, age 87.

THAGGARD, A. L., Madden. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1931; interned Memphis Methodist Hospital, Memphis, Tenn., one year; died Feb. 7, 1971, age 70.

Wyeth Adds to Tubex® Line

Wyeth Laboratories has added repository corticotropin injection U.S.P., 40 U.S.P. units (1.0 ml.) and 80 U.S.P. units (1.0 ml.), to its Tubex line of unit dose medications in pre-filled sterile cartridge-needle units. The new product is supplied in packages of 10 Tubex units.

Corticotropin, an anterior pituitary hormone commonly known as "ACTH," is used mainly to stimulate adrenal cortical activity in a functioning adrenal cortex. Over 30 steroids are produced and secreted under corticotropin's influence, and these steroids are indicated in treatment of a wide variety of diseases.

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Also, Wyeth's unit dose medications include an extensive selection of oral solids, liquids and suppositories in Redipak® single-unit packages for hospitals.

ACP Sponsors May Hypersensitivity Course

The American College of Physicians will present a seminar on immunologic concepts of hypersensitivity in man May 19-22 at the Statler Hilton in Buffalo, N. Y.

The seminar director is Dr. Carl Arbesman and co-director is Dr. Evan Calkins. A maximum of 200 physicians can register for the course which carries a credit of 22¾ hours toward AMA "Physicians Recognition Award."

The continuing medical education department of the School of Medicine of the State University of New York at Buffalo will assist the college in putting on the seminar.

For further information write: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Book Reviews

The Early Orthopaedic Surgeons of America. By Alfred Rives Shands, Jr., M.D. 190 pages with 156 illustrations. St. Louis: The C. V. Mosby Co., 1970. $15.00.

This small book, less than 200 pages, including introduction, summary, and index, is a masterful presentation of a great deal of detailed labor mostly on little known orthopaedists when in reality orthopaedics was not accepted as a specialty. As each of these 11 physicians is discussed in brief but petite detail, one can understand the ordeals that the early specialists in our field encountered, both in equipment and acceptance. It is also noted that many of these were accepted widely, especially on the European Continent, for their ability and their productivity and originality.

Some of the names mentioned will ring a bell with most anyone who reads this. Others will be surprised to learn of some obscure individual unheralded in our medical records for his great work. William Ludwig Detmold and Louis Bauer were both pioneers in this country from Germany. The later physicians, Lewis Albert Sayre, Henry Gassett Davis, James Knight, Virgil Pendleton Gibney, Charles Fayette Taylor, Newton Melman Shaffer, John Ball Brown, Buckminster Brown, Edward Hickling Bradford, and DeForest Willard, each has a very comprehensive chapter devoted to him and at the end of the book, there is a very brief sketch with a photograph of each of these men. Only five of these men lived into the present century, Dr. Shaffer expiring in 1938.

It is quite interesting to note that some of these somewhat unheralded early orthopaedists, who through necessity practiced other types of medicine, also contributed enormously to our present knowledge and foundation in conservative orthopaedics.

It is hoped that many will take the opportunity of reviewing the lives and works of these men. They will be found most interesting, and in many cases quite controversial in their day.

THOMAS H. BLAKE, M.D.

Surgery and Biology of Wound Repair. By Erle E. Peacock, Jr., M.D. and Walton Van Winkle, Jr., M.D. 630 pages with 338 illustrations. Philadelphia: The W. B. Saunders Company, 1970. $21.50.

This book represents a decade of thoughts, investigations, and clinical experience in biological research. The contents successfully bring into focus the basic principles of wound healing, and interestingly points out concepts, both proven and disproven, which strongly influence our understanding of wounds.

The first portion of the book deals with the natural biologic response of tissue to injury and carefully points out the fundamentals involved as healing occurs. This section is primarily oriented to the cellular level and is written so that it is easily comprehended by the clinician. After the initial discussion of wound healing, the succeeding chapters describe in detail the biology, the diagnosis, and the surgical management of injury to each organ. The chapter devoted to tendon and nerve injury is particularly well written and has ample illustrations.

It is apparent when reading this book that the authors are relating surgical experiences representing years of clincial medicine combined with years of research in the laboratory. I wholeheartedly recommend this book to the student of surgery, the teacher of surgery, and the practitioner of surgery.

BENTON M. HILBUN, M.D.

Clinical EEG Course Set for September

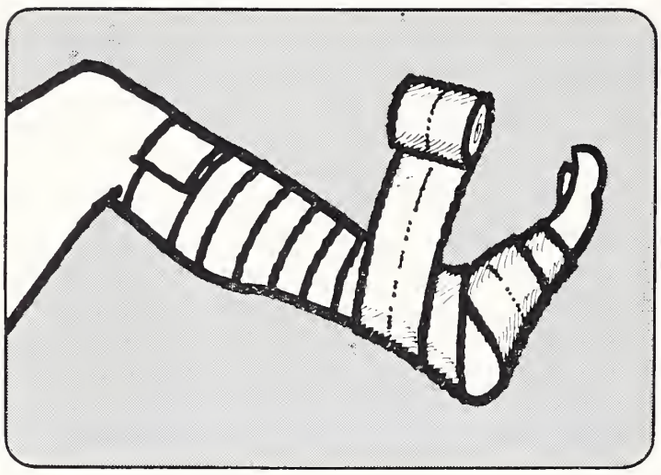
A continuation course on clinical electroencephalography will be held Sept. 13-15, 1971, in Minneapolis, Minnesota. The course is designed to review the principal applications of the EEG to clinical medical practice, and is sponsored by the American Electroencephalographic Society.

Inquiries about further details of the course or registration procedure should be addressed to Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, Rochester, Minnesota 55901.

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Thoracic Society Sets UMC Meeting

The 17th annual meeting of the Mississippi Thoracic Society, medical section of the Mississippi Tuberculosis and Respiratory Disease Association, will be held on Thursday, April 15, in Room 6-A, University Medical Center, in Jackson.

The theme of the scientific session for this one-day meeting will be "Pneumonia—Present Concepts of Etiology and Management." Featured guest lecturers will be Dr. Dick D. Briggs, Jr., director of Pulmonary Laboratories and Respiratory Disease Therapy, Carraway Methodist Hospital, Birmingham, and Dr. Robert S. Abernathy, chairman, department of medicine, University of Arkansas, Little Rock.

Dr. Briggs will discuss "Who Gets Penumonia and Why?" and "Pathophysiologic Manifestations of Pneumonia." Dr. Abernathy will speak on "Gram Positive and Negative Pneumonias: New Antibiotics, Mechanisms of Action and Rational Use."

Other speakers during the scientific session will include Dr. Joe R. Norman, Christmas Seal Professor of Respiratory Diseases, University Medical Center, speaking on "Defense Mechanisms of the Lung"; Dr. G. Boyd Shaw, clinical assistant professor of medicine, University Medical Center, "Nosocomial Pneumonias"; and Dr. Karl Stauss, UMC clinical assistant professor of surgery, "Complications of Pneumonia."

During the luncheon-business meeting scheduled at Primos Northgate Restaurant, Mr. Jack Curry, chief, Division of Air Pollution, Mississippi Air and Water Pollution Control Commission, Jackson, will speak on "Air Pollution in Mississippi—How Much?—What Is Being Done?" New officers will be elected during the business session, and several proposed activities in medical education will be discussed and approved for the coming year.

Dr. Antone Tannehill, Jr., Tupelo, Mississippi Thoracic Society president, will preside during the business session. Dr. Roland B. Robertson, Jackson, and Dr. John R. Williams, Greenville, co-chairmen of the Program Committee, will preside at the scientific sessions.

All interested physicians are urged to contact the Mississippi Thoracic Society, P. O. Box 9865, Jackson, 39206, telephone 362-5453, for further information and advance copies of the program.

Specialty Societies, Concurrent Meetings Highlight the 103rd Annual Session

More than 15 specialty society and related activities will hold concomitant meetings with the association's 103rd Annual Session in Biloxi, May 3-6, 1971, at the Sheraton-Biloxi.

The American College of Surgeons, Mississippi chapter, has set its annual meeting for Tuesday, May 4. President Dawson B. Conerly, Jr., of Hattiesburg will preside over the scientific session beginning at 9:00 a.m.

Guest speakers include Drs. Judson G. Randolph, Washington, D. C.; Watts R. Webb, Syracuse; James H. Hendrix, Jackson; Jerry R. Adkins of Biloxi and H. Vann Craig of Natchez.

The Louisiana-Mississippi Ophthalmological and Otolaryngological Society will meet May 6-8 at the headquarters hotel. Beginning with the MSMA scientific Section on Eye, Ear, Nose, and Throat on Thursday, May 6, the society will hold an extensive scientific program over the ensuing weekend, including golf and tennis tournaments, a seafood jamboree and dinner dance.

Members of the Mississippi Urological Society will convene Monday, May 3, at the Sheraton-Biloxi. The luncheon will be followed by a business meeting and the Pyelogram Hour. Dr. William J. Slaughter of Meridian is president.

State radiologists will attend a special meeting on vascular radiology at the Broadwater Beach Hotel in Biloxi on May 2. Dr. James B. Barlow of Jackson is president of the Mississippi Radiological Society.

The Mississippi Orthopaedic Society will conduct a scientific and business meeting on Monday, May 3, followed by a cocktail party at 6:00 p.m. President Daniel J. Enger of Pascagoula will preside.

Following the section meeting on Tuesday morning, May 4, the Mississippi Ob-Gyn Society will have a luncheon. Dr. William R. Raulston of Hattiesburg is president.

Mississippi Society of Internal Medicine will conduct a luncheon meeting at noon on Wednesday, May 5, following the section meeting that morning. Dr. William C. Kellum of Tupelo is president and Dr. S. H. McDonnieal, Jr., of Jackson, is secretary.

Family practitioners will gather when the Mississippi Academy of General Practice sponsors a luncheon meeting on Wednesday, May 5 in the Top of the Sheraton. Dr. Rafael C. Sanchez, director of the Division of Continuing Medical Education at LSU School of Medicine, will be special guest speaker for the occasion. President William H. Parker of Heidelberg will preside. Dr. James O. Stephens of Magee is president-elect.

Dr. Carl A. Evers, president of the Mississippi Association of Pathologists, will preside over the executive committee and business meetings of the association on May 2 at the Sheraton-Biloxi. Monday morning will feature a special scientific session for the pathologists.

Four medical alumni meets are set for the convention week. Ole Miss medical alumni, their ladies and guests will meet on Monday, May 3, at the Sheraton-Biloxi. A general business meeting will be followed by the cocktail party and seafood jamboree dinner-dance. Dr. Robert H. Middleton, Jr., of Biloxi is program chairman and Charles William Price, alumni secretary, is in charge of arrangements.

Tennessee medical alumni will enjoy cocktails and dinner on Tuesday evening, May 4. Dr. Sidney O. Graves of Natchez is chairman and Mr. June Montgomery, UT director of Almuni Affairs, will be present.

Graduates of the Vanderbilt medical school will meet at a reception on Tuesday, May 5. Co-chairmen for the occasion are Drs. Archie C. Hewes and Edward C. Hamilton of Gulfport.

ORGANIZATION / Continued

Medical graduates of Tulane University will be feted at an informal cocktail party on Tuesday evening, May 4. Dr. Robert A. Little of Mississippi City is chairman.

The 18 living MSMA past presidents will enjoy a breakfast meeting on Wednesday morning, May 5. Dr. James L. Royals of Jackson, immediate past president, is host.

Members of the Fifty Year Club will be honored at a special luncheon on Tuesday. The annual reference committee breakfast will be held Monday, May 3.

Past presidents of the Woman's Auxiliary have scheduled a breakfast meeting on Wednesday, May 5. Mrs. Louis C. Lehmann of Natchez is hostess.

Other events include the association cocktail party, May 6 at 5:30 p.m.; and the annual golf tournament to be conducted at Sunkist Country Club on Wednesday. Dr. A. V. Hays of Gulfport is in charge of the golf tournament arrangements.

The headquarters hotel, the newly-opened Sheraton-Biloxi, is located immediately east of the Broadwater Beach Hotel. The convention complex consists of a nine-story tower fronting on the Gulf with five connected two- and three-story lanai units on the north or back. There are 300 rooms and suites and 30,000 square feet of public space for meetings and exhibits, a Grand Ballroom, the Del Rosa dining room and a luxury supper club, the Top of the Sheraton.

Dr. Suzuki Joins UMC Faculty

Dr. Akio Suzuki has joined the University of Mississippi School of Medicine faculty as associate professor. Prior to his appointment, Dr. Suzuki was co-director of cardiovascular surgery and director of the Cardiac Research Laboratory at St. Vincent Charity Hospital in Cleveland, Ohio.

A native of Japan, Dr. Suzuki holds the M.D. from Tokyo Medical and Dental University. He was an intern at Tokyo U. S. Army Hospital and Albany Hospital in New York. He did his residency at St. Vincent Charity Hospital and the University of Mississippi Medical Center.



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LETTERS

SIRS: Your editorial that appeared in the February 1971 issue of your JOURNAL was excellent and will certainly go a long way toward promoting the PAC in Mississippi and AMPAC.

You are also to be congratulated on the membership drive thus far. This may be a record-breaking year—in more ways than one—for the Mississippi PAC.

WILLIAM L. WATSON
EXECUTIVE DIRECTOR, AMPAC
CHICAGO, ILL. 60611

SIRS: I read with admiration your editorial on allied health professionals in the February issue of the *Journal of the State Medical Association.* Your summary was clearer and more succinct than any other I have read.

Our College is particularly concerned with the problems of allied health professionals. We have recently approved a joint statement on maternity care with our Nurses Association and the American College of Nurse-Midwives. We are also interested in breaking down the tasks performed by obstetrician-gynecologists, deciding the kinds of personnel that can perform them and, perhaps, eventually, setting educational and accreditation standards for such personnel.

I continue to derive pleasure and information from reading your excellent journal.

MICHAEL NEWTON, M.D., Director
AMERICAN COLLEGE OF
OBSTETRICIANS AND GYNECOLOGISTS
CHICAGO, ILLINOIS 60603

Olivetti Introduces New Adding Machines

Olivetti Corporation of America has introduced two new OCR adding machines, model E26 OCR and model E26GT OCR.

The two units are numerical source printers for the preparation of journal tapes for data entry in optical character recognition (OCR) systems. Both models feature automatic credit balance, capacity 12 digits listing, 13 digits total. They are available with either the 1428 or the OCR-A font, 7 symbols for each register, and automatic rewind for uniform take-up of the printed journal tape.

For additional information please contact: Olivetti Corporation of America, 500 Park Avenue, New York, New York 10022.

C. B. Mitchell Lectures Feature Drug Scene

The annual C. B. Mitchell Pre-Med Lectures of Mississippi State University will be held April 16-17 in Lee Hall Auditorium at Starkville.

The theme of this year's lectures is "The Drug Scene: A Symposium on Narcotics and Dangerous Drugs."

Guest speakers are Dr. Donald B. Louria, professor and chairman, Department of Public Health and Preventive Medicine, New Jersey College of Medicine and Dentistry, Newark; Dr. W. L. Jaquith, director of Mississippi State Hospital at Whitfield; The Honorable Crawford M. Martin, Attorney General of the state of Texas; and Dr. G. Carl Hester, Tuskegee, Ala.

A banquet will kick off the symposium Friday evening at 6:00 p.m. Dr. Louria will give the keynote address and a lecture at 8:00 when he will discuss the drug scene. All speakers will be available for questions afterward.

Dr. Hester will head off Saturday's sessions with a presentation on personal experiences with the drug problem. Dr. Jaquith will cover some psychiatric considerations of drug use. At 11:00 Attorney General Martin will discuss the legal aspects of drug abuse. Dr. Louria will discuss rehabilitation consideration of the drug addict and the Attorney General will give the closing remarks.

All parts of the symposium are open to any student or professional in medical or paramedical fields from the high school level up. Sessions in Lee Hall on Friday night and Saturday are open to the public, with special interest for individuals involved in student affairs, religion, law enforcement, rehabilitation, the legal profession and state officials.

Dr. John C. Longest, director, Student Health Center, said, "We would like to encourage physicians throughout the state to bring their high school students. We encourage all students and professionals in medical and paramedical fields, as well as teaching and administration, to join us for the seminar."

Registration will begin at 3:00 p.m. Friday, April 16, in the Union lobby.

The C. B. Mitchell Pre-Med Fund was set up in 1968 by MSU medical friends and alumni to enrich pre-medical studies at State. It was named in honor of the man who served MSU for 27 years as college physician.

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dications *Male:* Replacement therapy in testular hormone deficiency states. Prevents atroy of the accessory male sex organs following stration for as long as therapy is continued. potence and male climacteric symptoms when e to androgen deficiency. Primary eunuchoidn and eunuchism. Delayed puberty when eslished as not a simple familial trait. Indicated those symptoms of panhypopituitarism red to hypogonadism, however, appropriate renal cortical and thyroid hormone replacent therapy remain of primary importance. *male:* Palliation of androgen-responsive, adnced, inoperable breast cancer in women beeen 1 and 5 years postmenopausal or women whom castration has shown the tumor to be rmone dependent. Prevention of postpartum east manifestations of pain and engorgement; ere is no satisfactory evidence that this drug events or suppresses lactation per se. In osporosis androgens may be of adjunctive ue to adequate considerations of diet, calm balance, physiotherapy and general health moting measures. *Males and Females:* In the atment of protein depletion states which or in geriatric patients, in debilitation states, in ronic corticoid therapy, resistant fractures; ptorchidism; creating a positive nitrogen balce, tissue repair and other anabolic effects. drogenic steroids may produce a response in lastic anemias, myelofibrosis, myelosclerosis, nogenic myeloid metaplasia and hypoplastic emias due to malignancy or myelotoxic drugs. drogens are not of value in other anemias.

ntraindications Pregnancy (may virilize fele fetus), mammary carcinoma in the male, static carcinoma, severe liver disease, severe diorenal disease and severe persistent hycalcemia.

ecautions Employ with caution in young boys avoid precocious sexual development and emature epiphyseal closure. Androgens tend promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. idence and severity of edema have been nimal and have been associated only with h doses used for palliation of breast cancer. percalcemia may occur, particularly in patients h metastatic breast carcinoma; if this occurs drug should be discontinued. Changes in r function tests, such as increased BSP retion and SGOT levels, can occur during ther-. Jaundice has been rarely reported. If liver ction tests are altered, discontinue medican or reduce dose. Priapism is indicative of cessive dosage and is indication for tempoy withdrawal of drug. When treating protein pletion states or osteoporosis, an adequate t should be provided and prolonged immobilion avoided whenever possible. When treating lastic or hypoplastic anemias, androgen ther- should not replace other measure such as nsfusion, correction of iron deficiency, antiterial therapy, and the use of corticosteroids.

verse reactions Nausea, dyspepsia, menual irregularities, hepatic dysfunction, priam, edema, precocious sexual development, d premature epiphyseal closure in young tients have been reported. *Male*—Prolonged ministration or excessive dose may cause ibition of testicular function with oligospermia d decreased ejaculation volume. *Female*—rge doses or prolonged administration may oduce masculinization with signs such as hirism, deepening of the voice, enlargement of clitoris, acne, and sometimes, increased do.

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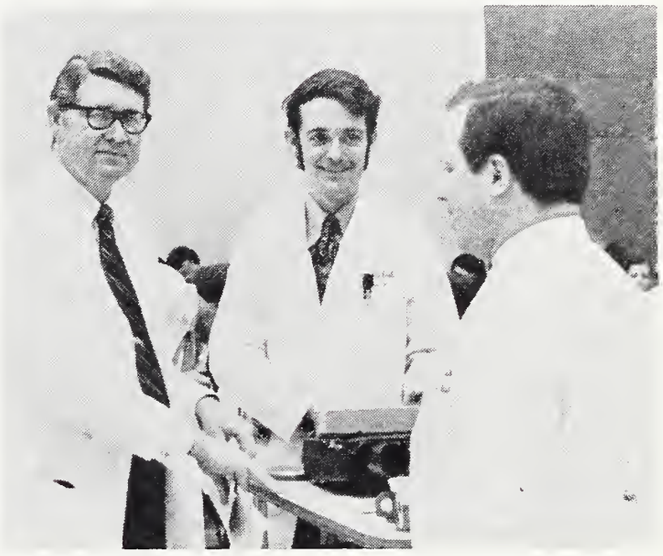
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Emory's Dr. Hurst Is Visiting Lecturer



Dr. J. Willis Hurst, left, Emory medicine chairman, was visiting professor of medicine and Southern Medical Association lecturer at the University Medical Center in February. Here, the noted cardiologist talks with medicine residents Dr. Jim McLeod and Dr. Mac Gorton about his S.M.A. talk "A New System of Education."

Tornado Victims Get Special Tax Processing

Special processing procedures have been established to expedite refunds, claims, and requests for copies of tax returns for taxpayers who have suffered losses by the recent tornadoes, J. G. Martin, Jr., District Director of Internal Revenue Service, has announced.

Residents of the 18 counties declared major disaster areas by the President may claim any tornado casualty loss on their return for 1970 or defer the loss until they file their 1971 return. If the taxpayer is claiming the loss on his 1970 return, he should send the return to his local IRS office or to the Internal Revenue Service, 301 Building, 301 North Lamar, Jackson, 39202. Following this procedure rather than mailing the return direct to the IRS Service Center will insure prompt attention and expeditious handling.

If a taxpayer has already filed his 1970 return and desires to claim the loss for 1970 he should file an amended return on Form 1040X in the same manner described above.


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Warning: Data supporting the use of PERITRATE (pentaerythritol tetranitrate) during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine, and many other agents.
Precautions: Should be used with caution in patients who have glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.
Adverse Reactions: Side effects reported to date have been predominantly related to rash (which requires discontinuation of medication) and headache and gastrointestinal distress, which are usually mild and transient with continuation of medication. In some cases severe persistent headaches may occur. In addition, the following adverse reactions to nitrates such as pentaerythritol tetranitrate have been reported in the literature: (a) Cutaneous vasodilatation with flushing. (b) Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. (c) An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur, even with the usual therapeutic doses. Alcohol may enhance this effect.
Dosage: PERITRATE SA Sustained Action (pentaerythritol tetranitrate) 80 mg (b.i.d. on an empty stomach), 1 tablet immediately on arising and 1 tablet 12 hours later.
Supplied: PERITRATE SA Sustained Action (pentaerythritol tetranitrate) 80 mg, bottles of 100 and 1000 tablets.
Additional Dosage Forms: PERITRATE (pentaerythritol tetranitrate) 10 mg and 20 mg tablets with or without phenobarbital 15 mg, bottles of 100 and 1000 tablets. PERITRATE with Phenobarbital SA Sustained Action—pentaerythritol tetranitrate 80 mg and phenobarbital 45 mg, bottles of 100 and 1000 tablets.
Warning: Tablets containing phenobarbital may be habit forming. PERITRATE with Nitroglycerin—pentaerythritol tetranitrate 10 mg with nitroglycerin 0.3 mg, bottles of 50 tablets.

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IRS Allows Magnetic Tape Reporting

Many organizations are taking advantage of the Internal Revenue Service Magnetic Tape Reporting Program which allows payers to submit magnetic tape records in lieu of paper Forms 1099, 1087, and W-2A, J. G. Martin, Jr., district director of Internal Revenue for Mississippi, said recently.

Tape reporting is not restricted to payers with the ability to submit all of their information on magnetic tape. A combination of tape records and paper documents is acceptable as long as there is no duplication or omission of documents.

The program is mutually beneficial since savings accrue both the payer and IRS. When magnetic tape is submitted in lieu of Form 1099 and/or 1087, payers are not required to furnish payees with copies provided the information as to earnings is otherwise furnished them. Payers filing magnetic tape in lieu of Forms W-2A must continue to furnish payees with the prescribed forms or paper substitutes which meet the requirements for substitute forms. This reduces the cost of the forms for the payer since one less copy is required. Savings are also realized through the reduction in paper handling, shipping charges and balancing operations.

Generally, payers using equipment compatible with IRS' can presume that tape reporting will be approved, if payers propose to submit incompatible tapes the Service will attempt to find conversion facilities.

Requirements and conditions for submission of magnetic tape records in place of original information returns are contained in Revenue Procedures 69-16 and 70-17. Copies of these procedures can be obtained from the district director's office, Internal Revenue Service, 301 Building, 301 North Lamar Street, Jackson, Mississippi 39202, or by writing the chief, Program Analysis Staff, P. O. Box 47-421, Doraville, Georgia 30340.

AMA Sponsors Long Term Care Conference

The American Medical Association will sponsor a conference on long-term care management of the patient in the long-term care facility on Saturday, April 24, at the Drake Hotel in Chicago.

The course will follow the annual meeting of the American Geriatrics Society, April 23-24.

Doctors' Wives Help With Arts Festival

Jackson's medical community has been well represented in the planning and preparation of the 1971 Mississippi Arts Festival. The fruition of their efforts—and those of hundreds of enthusiastic volunteers—will be seen on April 25 when the Festival gates swing open for an extraordinary, weeklong exposition of all the lively arts.

Grand opera's grandest star, Miss Beverly Sills, heads the impressive line-up of guest entertainers. The brilliant coloratura will lead an all-professional cast in a full-scale production of Donizetti's "Lucia di Lammermoor" on the evenings of April 27 and 29 in the Coliseum.

America's number one singing group, the Carpenters, will be the featured attraction for the entertainment-packed pops evening in the Coliseum April 30 and May 1. Famed pianist Peter Nero will also be presented in a special performance with the Jackson Symphony Orchestra.

The 1971 Production Committee charged with the over-all planning for the Festival includes Mrs. Richard L. Yelverton, wife of a Jackson surgeon, secretary to the group. Chairman of the Festival is Mrs. Davenport Mosby, with Mrs. Woodson Cowan as co-chairman. Mrs. Calvin L. Wells is treasurer and Mrs. Tim Jones is in charge of promotion.

In addition to the spectacular sights and sounds scheduled nightly in the Coliseum, a variety of experiences await an expected 150,000 Festival goers throughout the exhibition halls and along the midway.

Medical wives filling key chairman and co-chairman positions on various Festival committees are Mrs. Guy T. Gillespie, Jr., in charge of artists' arrangements; Mrs. Thomas Kilgore and Mrs. Roland Sampson, coliseum arrangements; Mrs. Charles M. Head, ushers.

Mrs. Richard C. Boronow, parking; Mrs. Alvin E. Brent, Jr., fairgrounds decorations; Mrs. A. W. St. Clair and Mrs. R. D. Sloan, information booth of the American Association of University Women; Mrs. James C. Hayes, junior high school art exhibits; Mrs. Bernard S. Patrick, literary seminar.

Mrs. James R. Cavett, Jr., mimeograph; Mrs. J. Manning Hudson, youth concerts; Mrs. T. Palmer Wilks, promotion display; Mrs. John H. Mills, coffee house decorations; Mrs. William Lockwood, youth division numbers.

Mrs. Chandler Clover, whose husband is administrator of Doctors Hospital, is in charge of newspaper promotion. Her assistant is Miss Barbara Austin, who is employed in the Office of Public Information at University Hospital.



Mrs. Richard L. Yelverton (right), whose husband is a Jackson surgeon, is secretary of the 1971 Production Committee of the Mississippi Arts Festival. The local medical community has been well represented in the planning of this year's extravaganza, which runs April 25-May 2. Other medical wives involved include Mrs. Charles M. Head (left), in charge of coliseum ushers, and Mrs. Alvin E. Brent, Jr., who is working on fairgrounds decorations.

For the first time this year, the Festival midway will be filled with attractions. A monumental free-form structure housing a participatory environmental exhibit will be the focal point. Visitors will be invited to experience—in an exaggerated form—the various sensory aspects of our environment. A colorful, open-air dining spot is another 1971 innovation for the midway. A small area of the tent restaurant will be transformed into a "Little Gallery" where Mississippi's finest native artists will display their works.

Other art exhibitions include the famed "Images on Paper," a select showing of national prize-winning artists, and the seventh annual Arts and Crafts Show. Five additional art displays insure that artists of every age and talent will be exhibited.

Back on the Festival midway, a portable foundry will be in continuous use as aluminum and bronze creations are cast. Sculptors, potters

and other artisans will also be exhibiting their compositions.

The Children's Division this year will be a delightful sensory happening for the youngsters, and will be supplemented by children's plays and four youth concerts by the Jackson Symphony Orchestra.

Ticket packets—priced at $5, $10 and $15—may be ordered by writing MAF Tickets, P. O. Box 4354, Jackson, Miss. 39216. Each packet includes two evenings of major entertainment in the Coliseum and one evening in the city auditorium, plus the exciting array of attractions on the Festival grounds.

Medical Center Has Family Planning Program

The University Medical Center initiated a new family planning counseling program for Mississippians in March. One of 10 pilot projects in the country, the counseling program is aimed at developing a model for family planning services.

A $52,152 grant from the American College of Obstetricians and Gynecologists and $10,000 from the Rockefeller Foundation supports the project.

State health officials estimate more than 100,000 women in Mississippi want and need family planning information, in addition to those who turn to the services offered by state health departments. Medical Center project planners hope to offer counseling to at least 1,000 women each year who don't currently have access to such services.

Initial program efforts will go to UMC patients. Counselors will explain available techniques and facilities for health care and family planning to each mother who delivers at University Hospital, as well as to patients who want, but don't have children. Those who wish these services will be referred to the family planning nearest their hometown.

An advisory board, comprised primarily of private citizens, will work with planners in organizing the program, according to UMC officials.

one capsule for the rest of the night

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Before prescribing, please consult complete product information, a summary of which follows:
INDICATION: Relief of insomnia of varied etiology.
CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.
Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.
Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.
PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.
ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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Medical School Trains Nurse Anesthetists

A long-awaited nurse anesthetist training program will swing into action at the University Medical Center this spring.

The critical shortage of nurse anesthetists in Mississippi, which prompted the 1967-approved program, has prevented officials from finding a training director until now, reported University Hospital director D. Andrew Grimes.

The two-year course, administered through the hospital anesthesiology department, will concentrate on both theoretical and practical instruction in the study of clinical anesthesia.

Program graduates will receive Medical Center certificates and be eligible to sit for certification exams of the American Association of Nurse Anesthetists.

Candidates for admission must be registered nurses with at least one year of nursing experience.

Med Sophomores Speak on Drug Abuse

Some 30 University of Mississippi medical school sophomores have temporarily switched from student to instructor as they talk with Jackson high school students about the physical dangers of drug abuse.

The hour "rap sessions" are a project of the Student American Medical Association, Mississippi Chapter, although not all participants are SAMA members. The sophomores opted to do the talks, explains class president Ed Searcy, because they've had pharmacology, and they have more "free" time than upperclassmen.

Each med student takes a classroom of students to explain what the most commonly abused drugs do to the body. Sessions are informal, loose. The young "instructors" encourage questions. One student talks to the faculty separately.

The sophs think their main selling point is that they don't preach. "I'm just here to let you know what I know," Searcy tells his groups. "We want to give them enough medically-based information for them to make up their own minds," John McCann adds.

The medical students look their dual roles. Wearing professional white jackets, they also sport varieties of sideburns, mustaches, and wire-rimmed glasses. To the teenagers, they look like they might know what they're talking about and also what their audience is thinking about.

All the sophomores feel the project is working, but they don't know to what extent. To judge, they depend on class response, the caliber of questions and the general rapport they establish.

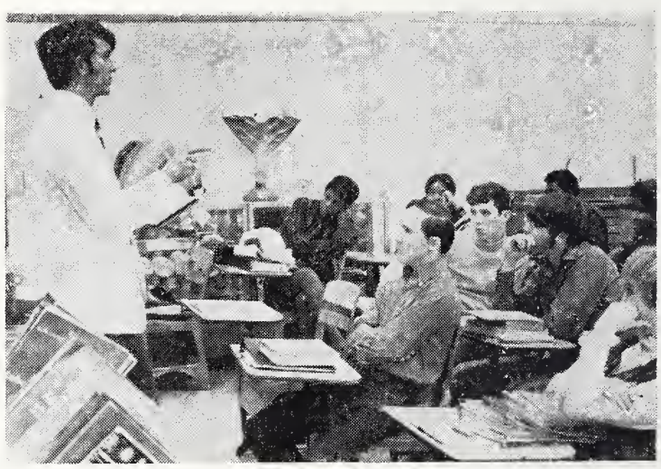
Another measure of success, they believe, is the growing number of high schools which have requested their service. Schools they've been to include Jackson Prep Academy, Murrah, Calloway, Jim Hill, Wingfield, Forest Hill in Jackson and All Saints in Vicksburg.

Whatever response they expected, most admit to being surprised—some by the teens' misinformation, others by how much some really know. "All high school students today have some kind of knowledge about drugs," reports Buddy Hardy. "Some of it's surprisingly accurate and some of it's completely off base. But everybody knows something, right or wrong."

The medical students agree the most frequent issue is marijuana, both from its physical and legal aspects. High schoolers are inquisitive about pills, too. "I was amazed at the combinations they'll try," says Phil Ricks, "just by taking a bunch of unidentified pills at what they call a



Teens talk with Byron Phillips after regular rap session.



Bill Harper gets his point across to an attentive group.

'potluck party.' They never consider the consequences."

That's the goal: to make them consider the consequences. Accomplish that, the med students believe, and the drug problem will begin to diminish.

Dr. Stead Speaks at 1st Boswell Lecture

Nearly 60 Mississippi physicians attended the first annual Henry Boswell Lecture in early March at the University Medical Center.

Guest speaker Dr. William W. Stead, medicine professor at the Medical College of Wisconsin, spoke on "Practical Implications of the Unitary Concept of the Natural History of Tuberculosis in Man."



Dr. William W. Stead, at right, professor of medicine at the Medical College of Wisconsin, was guest speaker for the first annual Henry Boswell Lecture at the Medical Center in early March. The lecture honors the distinguished physician who was first and only superintendent of the Mississisppi State Sanatorium. Talking with Dr. Stead is Dr. Joe Robert Norman, UMC Christmas Seal Professor of Pulmonary Diseases.

Patient education, stressed Dr. Stead, is essential. "Many patients will take their medicine for a while," he said, "then quit when they begin to feel better. We must educate them on why it's important for them to continue their medication even though they feel fine."

A continuing series, the Boswell Lectureship was established in honor of the late Dr. Henry Boswell, Mississippi pioneer in the fight against tuberculosis.

Dr. Boswell, a TB victim himself, served for 40 years as the first and only superintendent of the Mississippi State Sanatorium. He developed active tuberculosis in 1910 and took treatment in El Paso, Texas, sanatorium. A year later, he returned to Mississippi to become the first full-time public health worker in the state and the first full-time county health officer of Prentiss County.

In 1917 the TB crusader was named superintendent of the state's new sanatorium, which he headed until his death in 1957. During his distinguished career, Dr. Boswell served as president of the Mississippi State Medical Association, Mississippi State Hospital Association, Mississippi State TB Association, National TB Association, Southern TB Association and the American Trudeau Society.

The Mississippi Tuberculosis and Respiratory Disease Association supports the Boswell Lectureship, which is presented jointly by the Association and the University of Mississippi School of Medicine.

Dr. Robert E. Blount, Medical Center director and medical school dean, presided over the evening program. Dr. Guy D. Campbell, medicine associate professor, V.A. Hospital chief of pulmonary disease and M.T.R.D.A. Board member, spoke on Dr. Boswell. Executive director Judson Allred explained the role of the Mississippi Tuberculosis and Respiratory Disease Association. Dr. Joe R. Norman, Christmas Seal professor of respiratory disease, introduced Dr. Stead.

Dr. Flowers Participates in Title I Skin Clinics

A high rate of skin problems had been found to exist in the Coahoma County elementary schools by the school health adviser, Mrs. Marjorie J. Campassi, R.N.

Through the coordinated efforts of Dr. Richard H. Flowers, Greenwood dermatologist, and the county Title I School Health Services, a skin clinic was held at Friars Point Attendance Center.

Dr. Flowers examined some 58 children and recommended treatment to be carried out by the Title I nurses. Following the examinations, Dr. Flowers conducted a session on hygienic means to prevent skin problems. Title I nurses from Quitman and Coahoma counties and the Clarksdale Head Start program were invited.

Tentative plans are for Dr. Flowers to return to the schools in the same capacity during the next school year.

physician to own an interest in a for-profit hospital unless such ownership or interest is misused. The House was critical of present methods of reporting infant mortality, particularly by comparing statistics for the United States unfavorably with other countries which employ different criteria.

Dr. Wesley W. Hall of Reno, Nev., was elected president-elect, and your delegation had the privilege of being the first to second the nomination. There were no disruptions of the House by demonstrators and radical elements because of drastic security precautions.

Boston Clinical Convention. Principal actions at the clinical convention included government-sponsored health programs, medical education, policy on abortion, membership, peer review, and allied professional personnel.

President Bornemeier urged the profession to assume a role of leadership in health care delivery, even to instituting innovations such as neighborhood clinics and sponsorship of government programs. He reiterated his proposal for compressing the medical education process to six years with strong supportive postgraduate or continuing education programs.

Although there was reason to believe before the convention that the policy on abortion would be the subject of long and possibly bitter debate, the House reaffirmed the policy adopted at Chicago with brief discussion. A new classification of direct membership for interns and residents was approved. Dues prescribed are $20 annually, and membership must be converted to active or service after completion of training. The action is not mandatory, however, upon state medical associations already providing membership opportunity for interns and residents under dues exemptions, as has historically been done by our association.

The House reaffirmed its approval of physician-conducted peer review and the concept of Peer Review Organization (PRO) as contained in the AMA Medicredit bill. The House received information that the AMA had secured a number of desired changes in the then-pending Bennett Amendment to H.R. 17550: Deletion of pre-admission approval; no federal ownership of PSRO files; and removal of punitive fines.

The Judicial Council restated the "age old professional ideal of medical service to all, whether able to pay or not," and the House reaffirmed it. The recommendation was made because of many letters complaining of an apparent preoccupation by an increasing number of physicians with the financial aspects of their medical practice." AMA officially abandoned use of the terms "ancillary" and "paramedical" in official statements, using instead "allied." The House approved a recommendation from the Board calling for a moratorium on further licensure of new groups of allied professional personnel, pending further study and clarification of training and roles in patient services. The House rejected changes in the manner in which AMA Trustees are elected.

In other actions at Boston, the House urged improvement of outpatient coverage under insurance, voluntary prepayment, and government financing programs. The MECO project of summer externships for medical students was endorsed with the request that state medical associations assist.

An unwarranted, unpleasant, and untoward incident occurred at the annual medical service conference on Nov. 28 which immediately preceded the convention. An intern on the program who has been prominently associated with OEO-sponsored community action health programs in Mississippi made certain untrue assertions about the state of health care and medical licensure in our state. Your delegation protested these utterances to the AMA leadership.

Dr. Hicks presented a statement and read it into the record in the House of Delegates on Dec. 2 in which the charges were refuted. The chairman of the Michigan delegation, Dr. Donald Sweeney, endorsed Dr. Hicks' statement, and the House of Delegates voted to append it to the record of the medical service conference. It is also a matter of permanent record in the proceedings of the House of Delegates.

Expression of Delegates. Your AMA Delegates express their appreciation to our own House of Delegates, to the Board of Trustees with whom we sit at all meetings, and to the general officers for support, assistance, and continuing communication so that we may be properly prepared to represent your wishes and policy positions.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

102nd Annual Session. At the 102nd Annual Session in 1970, the House of Delegates approved three amendments to the By-Laws of the association:

Section 3, Chapter X, was amended to abolish the former Grievance Committee and establish the Committee on Peer Review as a constitutional body having nine members, one from each association district, appointed for terms of three years each. The duties of the committee are prescribed.

Section 4(a), Chapter I, was amended to pro-

vide exemption from state medical association dues for those members who have attained age 70, who have been in good standing for any 10 consecutive years. This exemption becomes effective on request by the member on Jan. 1 after the 70th birthday and continues so long as the member is in good standing in his component medical society.

Section 7, Chapter IX, was amended to increase the membership of the Council on Budget and Finance to five members from three members, the amendment to become effective at the 103rd Annual Session to provide for orderly arrangement and succession in the terms of the members of the expanded council.

Pending Amendment Proposal. On the concluding day of the 1970 annual session, Resolution No. 15, subject: Conduct of the House of Delegates, was introduced by Dr. Howard A. Nelson of Greenwood. This resolution proposes that Section 4, Chapter V, By-Laws of the association be amended to delete *Robert's Rules of Order, Newly Revised* as the parliamentary standard of the House of Delegates and substitute therefor *Sturgis Standard Code of Parliamentary Procedure*. The resolution shall have lain on the table for one year, and hearings on it and other business which may be brought before the council will be conducted on the afternoon of May 3.

There are no pending amendments to the Constitution.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties. The Council on Scientific Assembly is a constitutional body of the House of Delegates, charged with the responsibility of planning the annual session of the association to include all scientific activities, programming, and the scheduling of annual session events. The council membership consists of the chairmen and secretaries of the seven scientific sections and the secretary-treasurer of the association, a total of 15 members.

103rd Annual Session. Planning and organization of the 103rd Annual Session was initiated in the summer of 1970. The format suggested in the By-Laws and approved by the House of Delegates has been continued with general sessions centered around broad areas of specialty interests. To the maximum possible extent, conflicts in schedules and programming have been eliminated, although as a practical matter, such total elimination is not possible. In many instances, the council has requested and placed essayists from various specialty societies not represented in the Scientific Assembly before section audiences.

We are gratified that at the present annual session, 12 specialty groups have related or concurrent meetings with us. Four medical alumni groups have fraternal and social occasions, and various nonscientific but medically related bodies will meet during May 2-6. We continue to believe that providing for and encouraging these related meetings increases the attractiveness of the annual session to the membership and benefits attendance. We are glad to continue support of the Woman's Auxiliary and its concurrent annual session with us.

The morning scientific motion picture programs have been discontinued because of poor attendance. Only the mid-day programs have been scheduled. We are gratified with the presentations in the scientific exhibit, and we urge every member and guest to view these and the Technical Exhibits.

Technical Exhibit. Your council notes that ethical pharmaceutical firms, suppliers, and others eligible for purchase of space in our Technical Exhibit are declining our invitation to participate in growing numbers. This is not confined to Mississippi, because other state medical associations, major state specialty societies, and national organizations are having the same experience.

Harsh federal drug legislation, changing concepts in marketing, and tighter budgets for advertising are taking a toll of technical exhibit revenues. We have circularized more potential exhibitors than ever before, yet our present exhibit is one of the smallest in history. We continue to do all things possible to increase this participation.

Annual Session Funding. The Council on Budget and Finance and the Board of Trustees have requested your council to make the annual session financially self-sustaining. Appropriations for honoraria in the Scientific Exhibit were reduced by the Board to $300 for this annual session. Other economy measures have been instituted, including discontinuation of the annual association dinner-dance which experienced declining attendance. Instead, an association-wide cocktail party will be conducted which includes no dinner or entertainment. The admission assessment is accordingly decreased to a modest level to meet costs.

We cannot, however, guarantee that the present annual session will be financially self-sustaining, because revenues from exhibit sales are down, and many expenses necessary to minimum operations have increased with inflation. The management of the annual session is being accorded the closest attention by your council and the executive staff.

Headquarters Hotel. For about 20 years, the annual session has been conducted in two major Mississippi convention hotels. After 1968, the site was permanently moved to the Gulf Coast until convention facilities in Jackson were improved. After the 102nd Annual Session in 1970, your council requested the Board of Trustees to appoint a survey committee to examine other convention facilities on the Gulf Coast and make recommendations, since the Board recommends sites and dates for action and decision by the House of Delegates.

A committee consisting of our immediate past president, your council chairman, and a section officer from the Gulf Coast was appointed. As a result of its survey, the Board made the decision to terminate contracts with our former headquarters hotel and move the present annual session to the new Sheraton-Biloxi.

Expression of the Council. Your Council on Scientific Assembly is grateful for the support, cooperation, and assistance we have received in planning the 103rd Annual Session. We are aware that there will be problems in the new facility, both from the hotel as it adjusts to the massive task of servicing a complex convention and from us as we try to adapt to the new building and convention staff. We ask the help and understanding of all registrants toward the end that our annual session may be personally enjoyable and professionally profitable.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties. The Council on Medical Service is a constitutional body of the House of Delegates, consisting of nine members, one from each association district, elected for terms of three years each. There are three *ex officio* members who are our president, president-elect, and secretary-treasurer. The council is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under the council's jurisdiction are assigned activities of the association in medical service, emergency service programs, medical care for the indigent, and the work of allied medical agencies and organizations.

The council is assisted in its work by five committees, four constitutional and one *ad hoc,* all of which have conducted formal programs and activities during the 1970-71 association year. These embrace a wide range of subject areas in our purview of responsibility, including maternal and child care, mental health, occupational health, blood and blood banking, and nursing.

Mental Health. The chief concern this year has been with drug addiction and drug abuse. Our program of supplying information to physicians and the public on drug abuse has been increased, and a special kit of professional information, including reprints of scientific articles, policy statements, brochures, and suggested speeches, has been produced and furnished on request.

The community mental health center program has progressed with new and additional construction in the nine districts of the state. A major objective of the association was realized with the decision of the State Building Commission to construct the retardation center at Oxford, as voted in 1970 by the House of Delegates, and with the action of the 1971 Regular Session of the Legislature in funding construction and equipping.

At the time of preparation of this report, legislation is pending to formalize into statute the Interagency Commission on Mental Illness and Retardation. The association has supported this agency and the overall objectives of extending care for mental illness and retardation.

The chairman of the Committee on Mental Health, Dr. John J. Head of Jackson, resigned because of personal health and his retirement. The council commends Dr. Head for his leadership in this important area over the years.

Committee on Occupational Health. A major program of this committee is development of guides for occupational health programs in small plants in Mississippi, and individual members continue to prepare editorials and scientific articles for publication in the JOURNAL. A major deficit in state workmen's compensation statutes is lack of definition of injury and extent of coverage.

The committee has reviewed ongoing efforts in the 1971 Regular Session of the Legislature with reference to amendments to the workmen's compensation statutes. At the time this report was prepared, various bills were pending, both in committee and on calendars.

Dr. George D. Purvis of Jackson has submitted his resignation as chairman after serving 15 years. Your council commends his exercise of leadership, valuable contributions to the work of our association in this area, and his able representation of us before local, state, and national groups.

Maternal and Child Care. The continuing maternal death studies have been conducted by our committee and are now in the 14th year. A 10-year report on the studies will soon be published, and individual members regularly prepare case reports for publication. All of the study data are now computerized, and the committee has con-

ducted and published substudies on anesthesia deaths and hemorrhage.

The committee has continually reviewed legislative activities of interest within its field and has given valuable consultation in connection with the abortion amendments before the Legislature. Pertinent court decisions are also reviewed.

The chairman of the committee is Dr. William B. Wiener of Jackson. The committee consists of seven members, and three consultants in the fields of pathology, anesthesiology, and internal medicine assist.

Blood and Blood Banking. The committee is developing systems model for blood assurance and blood inventories programs which may be initiated on a pilot basis within a year. This would consist of computerized information centered around blood banks and blood assurance programs as to individual and family participation.

To assist in focusing attention on the urgent need for blood donors, the committee acted to secure a proclamation from the Governor proclaiming January 1971 as State Blood Donor Month. President Nixon issued a similar proclamation on National Blood Donor Month. A special commemorative postage stamp was issued in March in this same connection.

The committee has been deeply concerned about the *Cunningham* decision in Illinois where a hospital was liable for untoward effects of a blood transfusion, even though no negligence was involved. This was the first instance of application of strict tort liability to blood service. The committee noted that some legal authorities feel that our Mississippi statute stating that blood transfusions are a service and not a sale is no longer sufficient protection against this new legal doctrine.

At the time this report was prepared, remedial legislation providing immunity from strict tort liability (in the absence of negligence) had passed the House of Representatives in the Mississippi Legislature and was pending before the Senate.

Dr. Kenneth M. Heard of Jackson is chairman of this committee.

Nursing. The committee conducted extensive activities in 1970 with reference to mandatory licensure for nurses. The measure was passed by the Regular Session, and the association's policy position, adopted at the 102nd Annual Session was:

(1) The association supports mandatory licensure of nurses in principle, reserving the prerogative of making further changes and improvement and further reserving to the Board of Trustees final approval.

(2) The Committee on Nursing be utilized in consultation and testimony before the Legislature within the framework of policy because of the committee's familiarity and expertise in the matter.

The committee chairman has served as the association's representative on the nurse education advisory body to the Board of Trustees of Institutions of Higher Learning and on a special study group of that body charged with reviewing nurse education programs.

The committee takes the position that there should be no further licensure of allied health professions pending study and clarification of their respective roles in health care delivery. This is the position of the American Medical and American Hospital associations.

Active liaison is maintained with the Mississippi Nurses Association, and regular joint meetings with our committee are conducted.

The chairman is Dr. Tom H. Mitchell of Vicksburg.

Medicaid. Oversight of the Medicaid program as regards our association's interests was assigned to your Council on Medical Service. During September-December 1970, a special study on views of practicing physicians on Medicaid in Mississippi was prepared for the General Legislative Investigating Committee of the Legislature. The study report was released Jan. 4, 1971, immediately after publication Jan. 1 in the JOURNAL. Subsequently, the investigating committee furnished a copy of the study to each Senator and Representative.

The data were determined from 689 usable replies to the survey which inquired into three areas of concern among practicing physicians of Mississippi with reference to Medicaid:

(1) Physician participation.

(2) Fees paid.

(3) Comment, suggestions, and recommendations.

With reference to participation, we found that three out of four Mississippi physicians state that they participate in Medicaid by accepting patients and filing claims.

One out of five does not participate.

One out of six has participated but does not participate now.

One out of 12 has never participated.

Half of the physicians who do not participate in Medicaid give low fees paid as the reason.

A third of the nonparticipants say the reason is too much paperwork.

One out of nine is opposed to Medicaid.

A few submitted specific reasons for not participating, including slowness of payment.

A number of recommendations came from respondent physicians:

(1) Reduce paperwork for practicing physicians in preparing, filing, and reporting on claims.

(2) Pay better professional fees, preferably under the concept of usual and customary fees.

(3) Eliminate abuse of the program by patients.

(4) Relieve limitations imposed on the amount of medical care needed by the patient.

(5) Process and pay claims promptly.

(6) Eliminate dual claims procedure in Medicare crossover.

We found that more medical than surgical specialists participate in Medicaid. Eight out of 10 nonsurgical specialists participate, whereas two out of three surgical specialists participate. Areas of highest participation by physicians tend to appear with the highest impaction of recipients and major medical centers with the exception of East Mississippi and the Gulf Coast.

Medicaid Legislation. Growing out of the study was a measure for a substantial increase of professional fees under Medicaid, authorizing payment at the rate of the Blue Shield F-450 schedule from the present F-300 schedule. At the other extreme, the chairman of the House Appropriations Committee, Hon. Edgar Stephens of New Albany, also a member of the Medicaid Commission, introduced a bill to freeze physicians' fees for services under any state health program at $4 per unit on the 1964 California Relative Value Index. Both bills died without action in the Regular Session. The program is funded at about $41 million for fiscal 1972.

PMM Comprehensive Health Planning Report. The Division of Comprehensive Health Planning retained the services of Peat, Marwick, Mitchell and Co., a national accounting and management counsel firm to conduct a study on organization structure for publicly supported health activities in Mississippi. The report recommended a single commission with seven members, none of whom could be health professionals. Altogether, the plan would consolidate 20 budgeted entities consisting of 30 operating agencies into the single commission.

In this process, the State Board of Health would have been abolished, and all professional licensure, i.e., physicians, dentists, nurses, pharmacists, psychologists, etc., would have been placed under a single office of the commission. County health departments would have likewise been abolished in favor of 10 regional public health centers or units.

Legislation to implement the recommendations consisting of a series of bills considerably modified from the PMM recommendations *per se* was introduced before the Regular Session. One measure would have abolished the Board of Health and reconstituted a board of 11 members with only one physician. Medical licensure would have been removed to a separate medical board of examiners.

Other legislation introduced but not related to the PMM report would have renamed the Board of Health and divested it of medical licensure responsibilities. All such legislation was unsuccessful.

A special committee of the council considered the PMM report and met with representatives of the Division of Comprehensive Health Planning.

Expression of the Council. The council expresses special appreciation to its committees, some of which are among the most active working bodies of the association, and to our colleagues of the Board of Trustees who work closely with us. We deeply appreciated dedication of the third executive in our Central Office to the work of medical service, and we ask that he be replaced to continue to furnish urgently needed staff services for our programs.

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties. The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with the duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties, the Board shall have conducted six meetings in 1970-71 consisting of 12 meeting days since the 102nd Annual Session.

Seven officers sit with the Board of Trustees at all meetings. They are the president, president-elect, secretary-treasurer, speaker, vice speaker, and the two AMA delegates. The Board is assisted in its work by support of the executive staff. All 1970-71 meetings were conducted at Jackson.

This annual report includes actions on matters referred to the Board by the House of Delegates and items relating to management and policy functions which are among the Board's responsibilities.

Referrals from the House of Delegates. Matters referred to the Board of Trustees at the 102nd Annual Session and actions by the House requiring further actions by the Board include:

(a) *Resolution No. 2.* This resolution requires that we seek amendments to the abortion law permitting therapeutic abortion on written consultation by two reputable physicians where continua-

tion of the pregnancy constitutes a threat to the health of the patient, when the pregnancy results from incest, and for fetal considerations. The present law permits the procedure where a threat to the life of the patient is found and when the pregnancy results from rape. The resolution requires that the latter be defined in statute as "forcible" or "statutory." A suitable bill was prepared and introduced in the 1971 Regular Session of the Legislature but it died on the calendar in the House of Representatives. A bill which would have permitted abortion on demand was opposed by the association and killed in committee.

(b) *Resolution No. 3.* This resolution calls for authorizing limited licensure for selected foreign medical graduates for service in state medical institutions. A bill was drawn and introduced in the 1971 Regular Session. The measure passed both chambers and has been signed into law by the Governor.

(c) *Resolution No. 4.* This resolution requires the seeking of legislation which would require all who (are licensed henceforth) hold themselves out to diagnose and treat human illness to meet the same standards of education and training as doctors of medicine. After repeated meetings with the Attorney General, we found that implementation of the resolution would involve as many as five separate bills amending the Medical Practice Act. Failure of any one bill could have resulted in a legislative disaster, and the decision was made to withhold further action, especially in view of the defeat of efforts in both the House and Senate to license chiropractors. The Board of Trustees requests additional time in which to study means of implementing the resolution without endangering any aspect of the Medical Practice Act.

(d) *Resolution No. 6.* This resolution amended Section 4(a), Chapter I, By-Laws of the association, to provide exemption from dues for members who have attained age 70 and have been members of the association for any 10 consecutive years. Announcement of the amendment has been made to the membership through the JOURNAL and in writing to secretaries of component medical societies. The Executive Secretary informed each component medical society secretary of this new provision, and 12 of 29 eligible members have availed themselves of this dues exemption benefit at the time of preparation of this annual report.

(e) *Resolution No. 7.* This resolution calls for relief for physicians from burdensome procedures and paperwork in filing claims under the Mississippi Medicaid program. Soon after adoption, the Medicaid Commission simplified the physicians' claim form and undertook to provide for elimination of the Medicare claim crossover double filing. In late 1970, the association performed a study for the General Legislative Investigating Committee on views of practicing physicians on the program. The point of the resolution was reemphasized as well as additional views elicited in the study.

The Medicaid Commission has demonstrated interest in improvement of administrative aspects of the program and has addressed itself directly to matters contained in Resolution No. 7. The Board anticipates improvements in the program and will continue to work for objectives stated in the resolution and in previous policy.

(f) *Resolution No. 10.* This resolution is concerned with association financial management and is reported elsewhere in this annual report.

(g) *Resolution No. 11.* This resolution concerns support for Project CARE-SOM, the emergency medical helicopter services based at Greenwood, Jackson, and Hattiesburg. Support for the service was first given by the association through Gov. Williams' office and later, during the 1970 Regular Session of the Legislature. We supported House Bill 250 and Senate Bill 1903 permitting two or more counties to organize an air ambulance district, lease or acquire aircraft, provide for operation, maintenance, and crews, and conduct necessary communications activities. The effort was successful.

(h) *Resolution No. 12.* This resolution seeks federal tax credit for practice in a rural area. While the Board supports the resolution and principle, the Congress has been unresponsive in amending the Internal Revenue Code 1954 to accomplish this purpose. Other incentives, including enactment of a measure by the 91st Congress permitting draft-eligible physicians to elect to serve in rural and inner city areas in lieu of military service, offers much encouragement in relieving the problem which was addressed in the resolution. The association has initiated two positive programs in this connection: (1) publication of a new and expanded Physicians Placement Bulletin in partnership with the Ole Miss Medical Alumni Association and (2) intensified effort to improve rural medical service by the Council on Medical Service. Additionally, Sen. James O. Eastland has introduced legislation to assist in locating physicians in rural areas.

(i) *Resolution No. 13.* This resolution seeks to increase the supply of physicians in Mississippi by additional support for the University of Mississippi School of Medicine. The Board is glad to report that the University will accept its largest

beginning class in 1971, consisting of 95 freshmen. The association has supported increased appropriations for the medical school and has offered other good offices where and when support may be given.

(j) *Resolution No. 14.* This resolution urged that the state locate and construct the institution for the mentally retarded at or near Oxford. Immediately following the 102nd Annual Session, the resolution was transmitted to the Governor, the Board of Trustees of Mental Institutions, the State Building Commission, and the Interagency Commission on Mental Illness and Retardation. Representatives of the association met with state officials and presented the recommendation. On July 9, 1970, it was announced that the facility would be constructed at Oxford.

Nominations for the State Board of Health. No vacancies on the State Board of Health occurred in 1970, and it was therefore unnecessary for the House of Delegates to make nominations to the Governor at the 102nd Annual Session. Acting on nominations made in 1969 at the 101st Annual Session, Gov. Williams made the following appointments for six year terms: Public Health District, 2, Dr. G. Lacey Biles, Sumner; Public Health District 4, Dr. S. Lamar Bailey, Kosciusko; and Public Health District 5, Dr. Lamar Arrington, Meridian.

CHAMPUS. The association concluded its 14th year as fiscal administrator for the CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) program in Mississippi. The operation continues to grow with an increase in claims volume of 20 per cent and a dollar volume increase of 25 per cent in 1970, and it is a multimillion dollar operation. Compensation to physicians for professional services is made under the concept of usual and customary fees under medical peer control.

Less than 6 per cent of claims received are such that they are reviewed by the five-member review committee. Payment to physicians and others is made weekly. In January 1971, the Department of Defense severed the program from HEW regulations as to usual and customary fee determination, and payment is made solely on profiles of charges by Mississippi physicians.

JOURNAL MSMA. The JOURNAL has concluded its 11th consecutive year of continuous publication in 1970. It remains the largest single association-sponsored project and is a team effort among the Editors, Committee on Publication, and JOURNAL staff. The Board expresses appreciation to the Editors and committee in the production of this vital membership service.

Insurance Programs. There are approximately 2,100 contracts among 1,450 members in the association's two major group insurance programs. In addition to the Blue Cross hospitalization group, the association sponsors general accident, disability, health, and life programs with the Continental Companies and a professional liability insurance program with the St. Paul Companies. The association handles no premium collections nor processes claims. The Board takes the position that any profits or payments which might thereby accrue to the association should be passed along to participating members in the form of lower premiums or greater benefits.

About 1,400 contracts are in force in several Continental groups which are administered by the Thomas Yates Co. of Jackson, and the participants constitute more than 40 per cent of the membership.

There are about 700 participants in the St. Paul professional liability insurance program. We enjoy the fourth lowest premium rate in the United States, largely as a result of our carefully managed and monitored program under which claims review is available to any member against whom a claim or suit is threatened or initiated. The Board commends this program to physicians, pointing out its substantial monetary benefit in savings to members. The professional liability market has become a critical matter for most American physicians.

The Board urgently recommends that each member exercise care and diligence in securing this vitally necessary coverage and that threatened or instituted litigation be brought before the Board. We are not immune in Mississippi from the crisis in liability litigation which has come to so many states.

Himler Report. A major issue at the 102nd Annual Session was the Himler Report or Report of the AMA Committee on Planning and Development. The report contained many drastic departures in policy and medical practice pattern recommendations. Because of its drastic nature, the Board of Trustees made the decision to transmit the report in full text to the membership through the JOURNAL and to the House of Delegates.

In extended debate, the House of Delegates made the decision to divide the report into three categories: Those portions which merely reiterate previously approved policy; those which recommend information gathering; and those which are frankly controversial. The House directed that a

special committee or task force be appointed to deal with the report.

Further study, debate, and consideration were given the report and directives of the MSMA House of Delegates by the Board of Trustees which chose to constitute itself as the monitoring task force. In the meanwhile, other state medical associations took similar actions as opposition to controversial portions of the report mounted. At the AMA annual convention at Chicago in June 1970, the House of Delegates acted to recommit the report which had the effect of indefinite postponement. While the constitution of the Board as the special committee has thus become moot, the Board continues to monitor all developments in this connection. Moreover, the report has been communicated in full text to every member of the association. The Board recommends that no further action be taken.

Bicentennial of the United States. In 1976, the nation will observe its bicentennial, and appropriately, the AMA will conduct its annual convention at Philadelphia, the city in which the Declaration of Independence was signed. The City of Philadelphia and the Philadelphia Medical Society will construct a building to house a permanent Historical Museum of American Medicine, and our association has been invited to contribute a permanent exhibit on Mississippi medicine. The Board has considered something related to the work of Dr. Joseph Goldberger who discovered the cause and cure for pellagra at Jackson, 1912-14. The Board invites the membership to suggest other exhibits.

The Board reminds the House of Delegates that Philadelphia is the site of the first medical school in the United States and that the first graduate was a Dr. John Archer. Our 1964 president, the late Dr. John G. Archer of Greenville, was the fifth direct lineal descendant of the first American-trained physician.

In addition, the most distinguished museum in the nation, the Smithsonian at Washington, will present an exhibit in 1976 on American medicine as part of the Bicentennial observance. We have also been invited by the Smithsonian to participate in this project, lending or contributing some artifact representing Mississippi medicine.

Legislative Program. In 1970, the House of Delegates directed, in response to a special report of the Board and the address of our then-president, Dr. James L. Royals, that a new and intensive legislative program be developed and implemented. This consisted of production of a new weekly legislative newsletter, monthly meetings of the Council on Legislation during sessions of the legislature, regular meetings with key committees of the House of Representatives and Senate, daily staff representation at the Capitol, continuation of the Emergency Medical Care Unit at the Capitol, and doctor-to-legislator communications.

This program has been implemented, and the new "Mississippi Medical Legislative Report," a four-page weekly newsletter, has been furnished by first class mail to all members. The Council on Legislation initiated monthly meetings during which conferences are held with the public health committees of both chambers. The association has presented testimony, both oral and written, on a number of occasions, and our executives have represented us daily at the Capitol. The Board commends the Council on Legislation for developing and implementing this program.

Budget and Finance. Resolution No. 10, adopted in 1970, expanded the Council on Budget and Finance to five from its present three members, broadening the base of association financial management. Other actions corrected our procedures for preparation and approval of the annual budget by the council so as to observe fully the requirements of the By-Laws on our calendar fiscal year.

In accordance with Resolution No. 10, the Board has provided for orderly succession of the new members of the council, as outlined in the Report of the Secretary-Treasurer on vacancies in office. The council met in December 1970 and prepared the 1971 budget which was presented to the Board of Trustees in accordance with established procedures. The fiscal program shall have been reviewed by the Board in April, and the budget will be presented to the House of Delegates in the customary manner.

Both the Council on Budget and Finance and the Board of Trustees are gratified with this improvement which gives our growing operations and fiscal program a broader base of management selected by the House of Delegates and effectively corrects the lag in development of the annual budget.

Appointments. Under the provisions of Section 1, Chapter VII, By-Laws of the association, the appointive powers are vested in the president. During the 1970-71 association year, President Brumby made the following appointments and nomination, each of which has the endorsement of the Board of Trustees:

(a) *Delegates to AMA.* Following the resignation of Dr. Howard A. Nelson of Greenwood as Delegate to AMA, Dr. Stanley A. Hill of Corinth, then serving as Alternate Delegate to AMA, was appointed to serve the unexpired term through Dec. 31, 1970. In this capacity, Dr. Hill represented the association at the Chicago annual convention and the Boston clinical convention.

(b) *Alternate Delegate to AMA*. To serve Dr. Hill's unexpired term as Alternate Delegate to AMA, President Brumby appointed Dr. C. D. Taylor, Jr., of Pass Christian, who was Delegate-elect. On Jan. 1, 1971, Dr. Taylor entered his regularly elected term as Delegate, and Dr. Hill entered his regularly elected term as Alternate Delegate.

(c) *CHP Manpower Study*. The Division of Comprehensive Health Planning, Office of the Governor, has initiated a health manpower study. To represent the association on the study task force, President Brumby appointed Dr. Warren N. Bell of Jackson, who ably represented us in a similar study made in 1969 by the Mississippi Hospital Association.

(d) *Nomination to AMA Council*. President Brumby nominated Dr. William E. Lotterhos of Jackson for reappointment to the AMA Council on Scientific Assembly, and in December 1970, the AMA Board of Trustees made the reappointment.

Organization of the Board. One new Trustee, Dr. Lyne S. Gamble of Greenville, District 1, was welcomed to the Board during 1970-71, bringing to a total of seven new Trustees since 1967.

Officers of the Board during the year are Drs. Mal S. Riddell, Jr., of Winona, chairman; J. T. Davis of Corinth, vice chairman; and William O. Barnett of Jackson, secretary.

Summer Externship Program Gets Underway

More than 20 hospitals in Mississippi and Alabama have signed up to take some 26 students from the University of Mississippi medical school for summer externships.

Major project of the Student American Medical Association chapter at UMC, the externship program has been designated MECO for "Medical Education—Community Oriented." Co-sponsors for the program are MSMA and the Mississippi Hospital Association.

The purposes of MECO are to afford the medical student clinical experience in the local medical community and to encourage him to remain in his state to practice upon completion of his training.

Participating hospitals were requested to develop a program of 10 weeks' duration extending from the second week in June through August. The program should provide rotation to expose the student-extern to every facet of the hospital's operation.

Experience has demonstrated that it is profitable to assign the extern to one physician on the active medical staff. Externs shall have completed the first or second year.

The hospital will provide a stipend of $75 per week and make arrangements for the extern's room and board. Participating hospitals and the physician in charge include: Coahoma County, Dr. Steve C. Leist; East Bolivar County, Dr. R. T. Searcy; East Mississippi State, Dr. R. P. White.

Also Forrest County General, Dr. H. Lamar Gillespie; Greenwood Leflore, Dr. Clyde Smith; Itawamba County, Dr. G. A. Tubb; Jones County Community, Dr. W. B. White; Kings' Daughters in Greenville, Dr. John R. Williams; Gulfport Memorial, Dr. C. D. Taylor, Jr.; Northeast Mississippi at Booneville, Dr. Paul C. Ellzey.

Others are North Mississippi Medical Center at Tupelo, Dr. William L. Wood, Jr.; Pearl River County, Dr. Joe H. Powell; Stone County, Dr. J. W. Holmes; Tyler Holmes Memorial at Winona, Dr. M. S. Costilow; Walthall County, Dr. J. L. McLain; Lloyd Noland Hospital and Clinic, Fairfield, Ala., Dr. W. E. Riley; Perry County General, Dr. W. E. Moak; and Wayne General, Dr. W. W. Walley.

The hospitals were asked to observe certain guidelines in developing their externship programs. Externs should be trained to perform routine procedures based upon level of medical education and competency and should be allowed to function under supervision as part time help in various medical areas of the hospital. They should not be viewed as orderlies.

As a general introduction to clinical practice, students should be given instruction in physical examination and history taking. They should be permitted to follow individual patients where possible and to make rounds under their preceptor and attend seminars and conferences in the hospital.

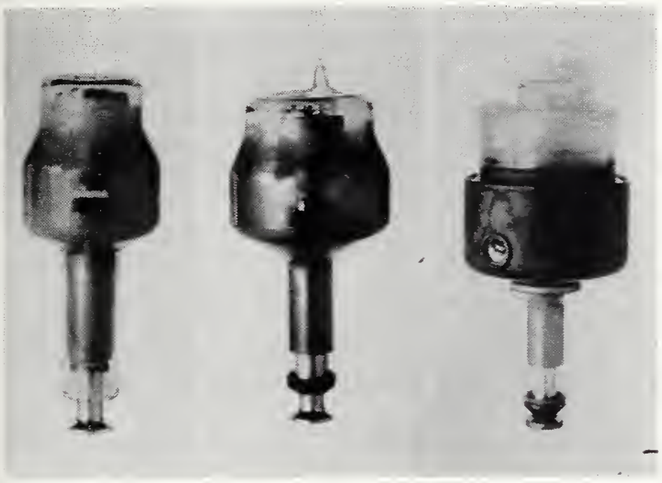
Students should be on call for observation of interesting cases seen in the emergency room, surgery and recovery. Externs should also have exposure to nonclinical areas in the hospital such as administration, medical records, community relations and computer utilization.

Dr. Paul B. Brumby of Lexington, MSMA president, has said, "I have confidence in the students and the value of the project to the education process. I hope that a maximum number of Mississippi hospitals will participate and that the medical staffs will contribute to this program."

Thomas V. Allen, Jr., of Vicksburg, a second year medical student at UMC, is MECO chairman.

G.E. Offers Maxiray X-Ray Tube Line

General Electric's new line of MAXIRAY heavy-duty x-ray tubes offers the power and performance to match the requirements of any radiographic and fluoroscopic procedure. From the MAXIRAY 75 to the MAXIRAY 125, featuring a five-inch rotating anode, this new tube line offers greater heat dissipation and storage capacity.



General Electric displays its new line of MAXIRAY heavy-duty x-ray tubes which offers greater heat dissipation and storage capacity.

All three tubes—the MAXIRAY 75, 100 and 125—feature GE's exclusive Polyrhenium (RTM) composite anodes. This construction permits higher instantaneous exposure ratings than ordinary tubes, resulting in more radiation with a smaller focal spot. The design also assures increased performance stability at high kVp, lower rates of radiation fall-off, and prolonged tube life.

The MAXIRAY 125 features anode thermal ratings of 400,000 heat-units storage and 100,000 HU dissipation per minute. The tube unit offers 1,750,000 HU storage and 60,000 HU dissipation. For radiography, the tube is mounted in the new GE 48-5 hanger. GE catheterization tables accommodate the tube for fluoroscopy and cine procedures.

Compatible with all GE generators, the MAXIRAY 100 offers anode thermal ratings of 300,000 HU storage and 75,000 HU dissipation. The tube unit provides 1,500,000 HU storage and either 50,000 HU (radiography) or 65,000 HU (fluoroscopy) heat dissipation per minute.

The MAXIRAY 75 is available with an integral oil-air heat exchanger or high speed blower for both radiography and fluoroscopy. The tube mounts on the GE 48-series hangers, the Model 65 tube stand, and in the TELEGEM 15 system. For fluoroscopy, it is accommodated in the GE Monitrol tables and catheterization tables. Thermal ratings include: anode—300,000 HU storage and 60,000 HU dissipation per minute; tube unit—1,250,000 HU storage and either 60,000 HU (with heat exchanger) or 40,000 HU (with blower) heat dissipation per minute.

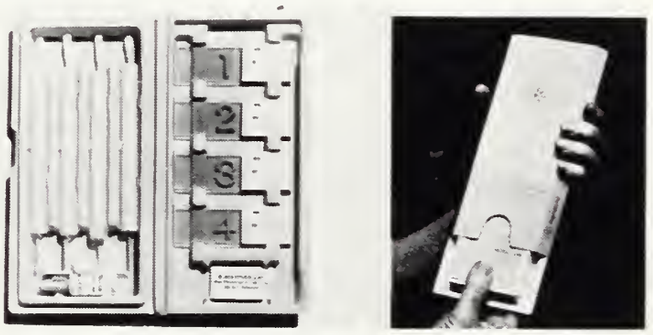
For more information on the new MAXIRAY tube "family," write General Electric Company, Medical Systems Department, 4855 Electric Avenue, Milwaukee, Wisc. 53201.

Portable Estrogen Kit Developed

A new kit that enables the physician to determine accurately estrogen levels for the first time in his own office is announced by Diagnostic, Inc., 4030 West 10th Street, Indianapolis, Indiana 46222.

Known as Gyndex, the kit features four unique pre-calibrated slides for use with the vaginal smear technique. A pattern of grids and dots on the slides acts as references and permits the physician to make a fast, accurate analysis of cells. Interpretation of the slides may be performed in the doctor's office immediately by the doctor or an assistant.

A series of four weekly smears is recommended, each taken at the same time of day, either in the physician's office or patient's home. After the



Each Gyndex kit contains everything needed to perform the test.

smear is obtained, the physician or assistant places two drops of a special cellular dye on each smear, the smear is covered with a cover glass and the slides are ready for evaluation.

Each kit is complete in itself with no additional items required to perform the test. Each kit contains four slides, four insertion tubes, four rayon-tipped applicator sticks, four cover glasses, vial of cellular dye, and complete step by step instructions for both patient and physician.

The price is $14.50 for a package of three kits containing 12 tests. This is a cost of $1.21 per test to the physician.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 20-24, 1971, Atlantic City, Clinical Convention, Nov. 28-Dec. 1, 1971, New Orleans. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

STATE AND LOCAL

Mississippi State Medical Association, 103rd Annual Session, May 3-6, 1971, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Mississippi Academy of General Practice, Annual Assembly, June 24-26, 1971; Biloxi. Miss Louise Lacey, Executive Secretary, P.O. Box 3112, Jackson 39207.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Robert P. Henderson, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Second Wednesday, April and First Wednesday, November, 2:00 p.m., Clarksdale. Glenn L. Wegener, 1967 Hospital Drive, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. James E. Booth, Eupora, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. A. Robert Dill, 1001 Main Street, Columbus, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Robert Donald, Box 1351, Pascagoula, Secretary.

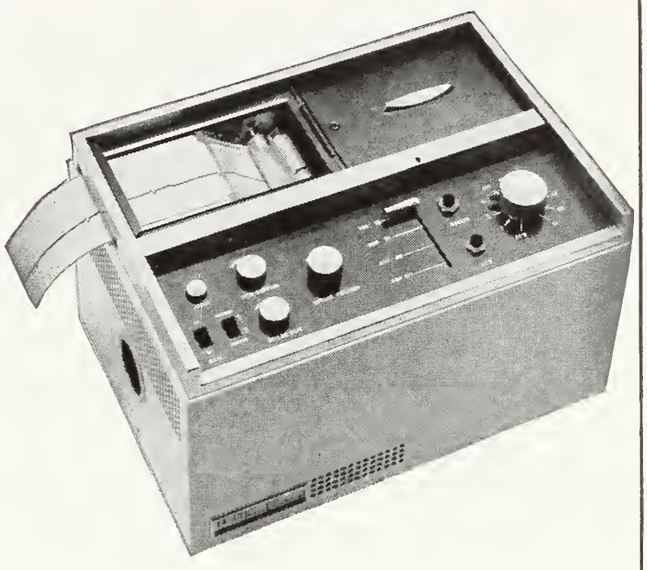
South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie Street, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday, January, April, July, and October, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.

$30,000-$40,000 guaranteed first year. Locations in Alabama and other Southern States for General Practice and Internal Medicine. Minimum practice expense. Maximum leisure time with family. Not an employment agency. No cost to physician. Sanford Smith, Director, Physician and Personnel Planning, P. O. Box 9836, Houston, Texas 77015. 713-453-6324.

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IN CONCLUSION

Do not - says association's CHAMPUS Department - put old four-digit procedure code on DA Form 1863-2 when filing claims. Program is changing to new five-digit codes in AMA Current Procedural Terminology, 2nd Edition. Use of old codes can slow processing of payments. Best way to prepare claims is to describe precisely the surgical procedure or medical service performed. Be sure to get correct data from beneficiary's ID card, too.

MADOC is the new word for Medicare Analysis of Days of Care, a new statistical study service by SSA. Semi-annual reports will be made on 275 geographic areas of U.S., each to include five to 50 hospitals and 1,000 beds. Computerized reports will be based on 20 per cent sample of Medicare claims showing overall length of stay by surgical procedure and 10 most common diagnoses. Reports will be sent to hospitals and Medicare intermediaries.

Except in preposterous Kennedy health insurance bill, almost no mention of dental services is made in host of other measures before Congress and maze of other national health plans. Mystery is explained in part by most dental services being postponable, exerting less financial pressure on patients. Dental society-sponsored service corporations, voluntary postpayment plans, have also been slow to develop.

Blue Shield breakthrough for chiropractors came in Michigan with enactment of state law requiring payments to cultists. State chiropractic association fought 10 years for legislative victory that makes Blue plan pay for office adjustments and x-ray diagnosis. Biggest surprise is failure of Michigan State Medical Society and UAW to block enactment, since organized labor is both largest Blue plan buyer in state and is committed against chiropractic.

Methadone maintenance of narcotics addicts has been declared acceptable medical practice if conducted under carefully controlled conditions and proper supervision. Policy was jointly issued by AMA and National Research Council but pointed out that it is not feasible for office practice, since private M.D. cannot provide all needed therapeutic services for addict-patient. Pronouncement was made independently of Judicial Council with no overtone of ethics

Volume XII
Number 5
May 1971

JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $7.50 per annum; $1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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THIS MONTH

The President Speaking **256** 'A Matter of Stewardship'

Medical Organization **267** University Medical Society to be Chartered at 103rd Annual Session

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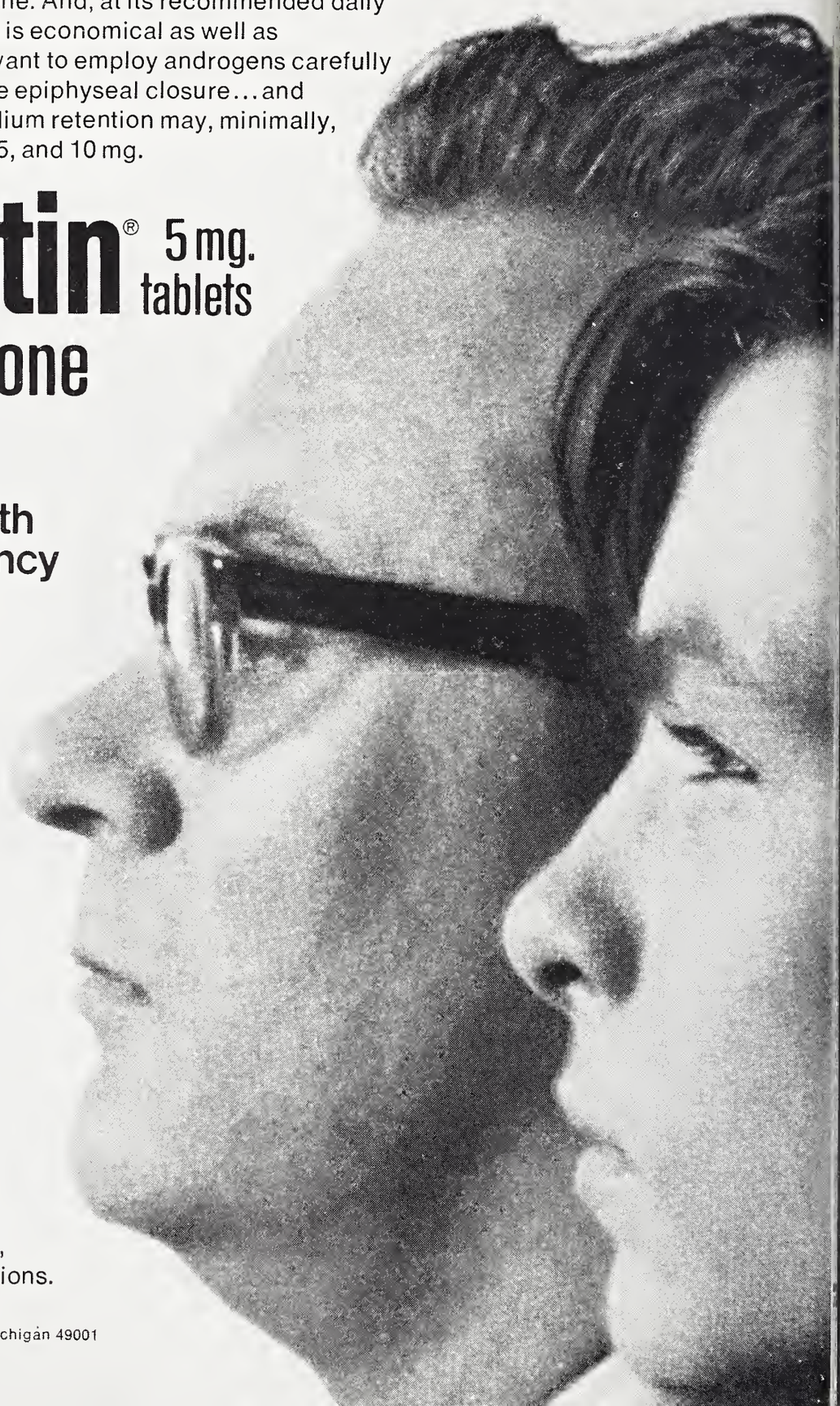
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Please see facing column for summary of contraindications, precautions, and adverse reactions.

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cations *Male:* Replacement therapy in tes-lar hormone deficiency states. Prevents atro- of the accessory male sex organs following tration for as long as therapy is continued. otence and male climacteric symptoms when to androgen deficiency. Primary eunuchoid- and eunuchism. Delayed puberty when es-ished as not a simple familial trait. Indicated those symptoms of panhypopituitarism re-d to hypogonadism, however, appropriate enal cortical and thyroid hormone replace-nt therapy remain of primary importance. *Male:* Palliation of androgen-responsive, ad-ced, inoperable breast cancer in women be-en 1 and 5 years postmenopausal or women whom castration has shown the tumor to be mone dependent. Prevention of postpartum ast manifestations of pain and engorgement; e is no satisfactory evidence that this drug vents or suppresses lactation per se. In os-porosis androgens may be of adjunctive e to adequate considerations of diet, cal-n balance, physiotherapy and general health moting measures. *Males and Females:* In the tment of protein depletion states which oc- in geriatric patients, in debilitation states, in onic corticoid therapy, resistant fractures; torchidism; creating a positive nitrogen bal-e, tissue repair and other anabolic effects. rogenic steroids may produce a response in astic anemias, myelofibrosis, myelosclerosis, ogenic myeloid metaplasia and hypoplastic mias due to malignancy or myelotoxic drugs. rogens are not of value in other anemias.

traindications Pregnancy (may virilize fe-e fetus), mammary carcinoma in the male, static carcinoma, severe liver disease, severe diorenal disease and severe persistent hy-calcemia.

cautions Employ with caution in young boys avoid precocious sexual development and mature epiphyseal closure. Androgens tend romote retention of sodium and water, there-, watch for edema—particularly in the elderly. dence and severity of edema have been imal and have been associated only with n doses used for palliation of breast cancer. ercalcemia may occur, particularly in patients n metastatic breast carcinoma; if this occurs drug should be discontinued. Changes in r function tests, such as increased BSP re-ion and SGOT levels, can occur during ther-. Jaundice has been rarely reported. If liver ction tests are altered, discontinue medica- or reduce dose. Priapism is indicative of essive dosage and is indication for tempo-withdrawal of drug. When treating protein letion states or osteoporosis, an adequate should be provided and prolonged immobili-on avoided whenever possible. When treating astic or hypoplastic anemias, androgen ther- should not replace other measure such as nsfusion, correction of iron deficiency, anti-terial therapy, and the use of corticosteroids.

erse reactions Nausea, dyspepsia, men-al irregularities, hepatic dysfunction, pria-n, edema, precocious sexual development, premature epiphyseal closure in young ents have been reported. *Male*—Prolonged inistration or excessive dose may cause bition of testicular function with oligospermia decreased ejaculation volume. *Female*—ge doses or prolonged administration may duce masculinization with signs such as hir-sm, deepening of the voice, enlargement of clitoris, acne, and sometimes, increased do.

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AAP Cautions Against Infant Swimming

Large-scale programs should not be undertaken to teach swimming to children under three years of age, the American Academy of Pediatrics has recommended in a statement issued in a recent *Newsletter.*

The statement, developed by the AAP's Joint Committee on Physical Fitness, Recreation and Sports Medicine, emphasized that children less than three years old are most vulnerable to drowning.

"Recent efforts have been focused on teaching young children to swim, even during the first year of life. It may be possible to teach very young infants to swim and keep their heads above water, but an infant cannot truly be taught water safety and proper reaction to an emergency," the Academy cautioned. "Parents can develop a false sense of security if they know their young infant can swim a few strokes."

The Academy's Joint Committee on Physical Fitness, Recreation, and Sports Medicine also cited the problems caused by admitting infants to public pools.

Infants lacking sufficient self-restraint create difficulties in maintaining the effectiveness of chlorination, the Joint Committee pointed out. Also infants with age-specific immunity handicaps (infants not as immune to certain specific diseases as older children), would be exposed to intestinal viruses, adenoviruses (viruses causing upper respiratory disease), and "other potentially dangerous microorganisms in dosages not likely to be found under home conditions."

"Considerations involved in the use of swimming as a form of patterning are not of sufficiently established benefit to be weighed as factors in favor of early pool training," the statement indicated.

The Joint Council recommended the following guidelines to reduce the incidence of drowning in children under three: more adequate fencing and other protective measures to exclude infants from pool areas and areas of excavation; assurance of constant parental or other adult supervision for nonswimmers in swimming areas; and use of flotation jackets for all nonswimmers close to bodies of water or in boats.

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NEWSLETTER

May 1971

ar Doctor:

teopaths have been given full medical practice prerogatives by
e Arkansas legislature with blessings from Gov. Dale Bumpers.
ly condition is that D.O. must have had one year of AMA-approved
ternship or two years of postgraduate training within past five
hospital approved by American Osteopathic Association. Before
ssage, Arkansas law limited osteopathy to manipulation.

Arkansas becomes 48th state to open doors to D.O.'s and law was passed over opposition of state medical society. Gov. Bumpers supported bill as means of getting better health services in rural areas. When measure was enacted last month, Arkansas had only seven osteopaths.

. Gunnar Myrdal says his native Sweden is a "welfare state gone
d" as handouts, inflation, taxes, and demand for benefits zoom.
eden faces serious crisis economically as unions of top profes-
onals strike against state. Tax burden is crushing, and infla-
on eats up growing cash and service benefits of government. Dr.
rdal says U.S. welfare system is approaching same trouble.

esident Nixon has rescinded a Pentagon policy on liberalized
ortion in military hospitals, requiring adherance to state law.
der came last month from Western White House at San Clemente
ere President said that he opposed abortion on demand and con-
dered it "an unacceptable form of population control." Liberal
litary policy rescinded was made by Defense Secretary Laird.

A crackdown on combination ingredients in all Rx and over-the-
unter products will affect up to 40 per cent of entire market.
ay see move as usurpation of medical practice privilege by FDA
d as beyond its authority in statute. Basis for action is the
-called "safety and efficacy" requirement for pharmaceutical pro-
cts. Virtually all proprietaries are combinations sold OTC.

dicolegal decision of the century may have been handed down in
ntgomery, Ala., federal district court. Ruling is that mental
tients, once committed, have a constitutional right to treatment
fording a realistic opportunity to be cured. State of Alabama has
x months to implement decision, and chances are that opinion will
applied by precedent in every other state by new lawsuits.

Sincerely,

Rowland B. Kennedy
Executive Secretary



DATELINE

urance Exec s NHI Danger

Atlanta - A top insurance executive, Thomas A. Watson of Lincoln National Life, says that the U.S. cannot legislate health services. Referg to pending national health insurance proposals, Watson said gress can legislate money but it can't decrease need or increase ply of service in that manner. He warned against pitfall of beving that any NHI bill could or would change the health picture. her, he said such enactments would merely add to problems.

---

yer Is Made to it Suit Fees

Sacremento - A California attorney was made to split fees on his medical malpractice winnings by his own state courts. Case was that lawyer referral on a medical malpractice suit which he won and received ,000 for his services. Referral source asked for usual third, lawyer sued, claiming it required him to split fees. But court d that referral fees are legal and made him fork over $16,000. e is Emmons et al v. State Bar of Calif. 86th Cal. 367, Apr. 70.

---

lex Trainees ish UA Class

Birmingham - The first Medex physicians' assistants have been assigned to rural practitioners after training at University of Alabama Medical ter. Program is structured to reorient former medical corpsmen armed services to private practice and is one of four now being ducted. Course is eight months and is predicated upon training l experience of corpsmen in military service. UA had 24 enrollin first class, and others are in training.

A-ACHA Warn of ta Compromise

Chicago - AMA and American College Health Association have expressed fear that confidential student health records are being compromised to authorized sources in rapid expansion of institutions and rush of dents to enter. AMA and ACHA urge that student health records sent to institution's M.D. school health director or the college alth service. In schools without a health director, interpretaon of information rather than M.D. records should be sent.

W Cracks Down on dicaid Payments

Washington - In a further crackdown on alleged Medicaid abuses, HEW has ordered all states to report payments to providers, identifying them name, address, and Social Security number. Move brings to mind troversial action of Senate Finance Committee last year on disosing names of M.D.'s receiving high payments under program. On- six convictions have been made for fraud under Medicaid, despite yment of billions in satisfaction of millions of claims.

Dr. Miller Will Head UAB Rehabilitation

Dr. John M. Miller, III, has been named director of rehabilitation programs for the University of Alabama in Birmingham, director of Spain Rehabilitation Center, and director of the UAB Medical Center's Rehabilitation Research and Training Center.

The announcement was made by Dr. S. Richardson Hill, Jr., UAB vice president for health affairs, who said that Dr. Miller's new responsibilities will be in addition to his current position as professor and chairman of the Department of Rehabilitation Medicine in the UAB School of Medicine.

Dr. Miller assumes the position left vacant by the death of Dr. Edward M. Holmes, Jr., February 26, 1971.

Prior to his appointment with UAB in June, 1970, Dr. Miller was on the faculty of the College of Physicians and Surgeons of Columbia University and was acting chief and consulting physician of the Physical Medicine and Rehabilitation Department, Englewood Hospital, Englewood, N.J.

A native of Cordova, Ala., Dr. Miller was graduated from Vanderbilt University, Nashville, Tenn., and the UAB School of Medicine. He served his internship and residency in Brooklyn, N.Y., and New York City.

Dr. Miller is a diplomate of the American Board of Physical Medicine and Rehabilitation.

Internal Medicine Seminar Slated

The American College of Physicians will present a seminar on internal medicine: clinical problems 1971, June 7-11 at the University of Cincinnati Medical Center.

Dr. Richard W. Vilter is director of the seminar which carries a credit of 35 hours toward the AMA "Physicians Recognition Award."

Current clinical problems in internal medicine will be discussed with emphasis on pathophysiology and management. Topics will be selected from the fields of gastroenterology, infectious diseases, endocrinology, hematology, renology, cardiology, immunology, pulmonary disorders, clinical pharmacology and rheumatology.

For further information, write: the Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Penn. 19104.

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CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
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HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Tuberculosis Drug May Halt Leukemia Transfer

An antibiotic, originally designed to treat tuberculosis and then consigned to a laboratory shelf, may one day prove to be another useful agent in the treatment of leukemia and other types of cancers.

The hopes advanced by collaborating scientists from the Upjohn Company in Kalamazoo, Mich., and Johns Hopkins Medical School in Baltimore are predicated on two recently reported findings about the nature of cancer growth, and on work in their own laboratories. A preliminary article on their work was published in the March 26 issue of NATURE, a leading British science journal.

Co-authors of the paper are Drs. William W. Brockman and William A. Carter of Johns Hopkins and Drs. Li-Hsieng Li, Fritz Reusser, and F. Richard Nichol of The Upjohn Company.

Only last May, Dr. Howard M. Temin of the University of Wisconsin reported on an enzyme which could transfer genetic information from the RNA of a virus cell to the DNA of a normal cell, causing the normal cell to take on the characteristics of cancer and duplicate itself many times in that malignant form. Before that time, it was felt that RNA could not serve as a template for DNA. Although viruses were suspected as a cause of cancer, there had previously been no clear delineation of the mechanism by which an RNA virus could function as a causative agent. Dr. Temin's observations were confirmed by simultaneous and independent studies by Dr. David Baltimore of Massachusetts Institute of Technology.

Shortly after the discovery of the enzyme (reverse transcriptase), a number of researchers confirmed that the enzyme is found in animal and human cancer cells, but apparently not in normal cells. This raises the possibility that the enzyme is needed for a virus to induce leukemia, and perhaps other types of cancer, and that by blocking the enzyme one could stop the production of malignant cells.

With a background of information about inhibitors of nucleic acid synthesis enzymes that was available from Upjohn research on the mode of action of antibiotics, the Upjohn scientists turned to a group of antibiotic compounds called streptovaricins and contacted the Johns Hopkins scientists who already had a tumor virus testing system established. The Upjohn drug had been discovered some 15 years ago and tested as a possible treatment for tuberculosis.

Dr. Pauling Receives ASA Annual Award

Dr. Linus Pauling, professor of chemistry, Stanford University, two time Nobel Prize winner and author of *Vitamin C and the Common Cold,* is the recipient of the American Schizophrenia Association's first annual award, Donald C. Webster, chairman of the Board of Trustees, has announced.

The award is in recognition of Dr. Pauling's pioneering work in the field of orthomolecular psychiatry and was presented at a luncheon honoring Dr. Pauling held at the Biltmore Hotel in New York, on April 2.

Senator Harold Hughes (D., Ia.) is serving as honorary chairman, with Mr. Webster and Mrs. Aldous Huxley as co-hosts. Mrs. Huxley, a member of the Board of Trustees, is a practicing psychotherapist and author of *You Are Not the Target* and *The Timeless Moment.*

Prior to the luncheon, a symposium sponsored by the Association will be held in the hotel on "Modern Chemotherapy of Brain Disorders." Speakers and their topics will include Dr. Loren R. Mosher, chief, Center for Studies of Schizophrenia, National Institute of Mental Health, Washington, D. C.; Dr. David R. Hawkins, medical director, North Nassau Mental Health Center, Manhasset, N. Y.; Dr. Abram Hoffer, psychiatrist, Saskatoon, Saskatchewan; Dr. Allan Cott, psychiatrist, New York City; and Dr. Pauling.

Other participants will include Dr. Thomas A. Ban, Douglas Hospital, Verdun, Quebec; Dr. Moke W. Williams, psychiatrist, Miami; and Dr. Jose A. Yarura-Tobias, North Nassau Mental Health Center, Manhasset, N. Y. Dr. J. Ross MacLean, President of the Association, will act as Moderator.

The American Schizophrenia Association was founded in 1964 in the belief that the two million Americans who suffer from schizophrenia and related brain disorders could be better served and treated through the development of programs utilizing recent advances in biochemistry and related fields in research and training, public education and improvement of service facilities.

The nonprofit, voluntary agency was organized by some of the foremost schizophrenia researchers in North America. These eminent scientists believe that schizophrenia, "The Plague of the Twentieth Century," can be brought under control in the future and ultimately eradicated if sufficient public support can be mobilized for the conquest of this tragic illness.

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Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
May 1971, Vol. XII, No. 5

ORIGINAL PAPERS

Management of the Obese Diabetic

BURIS R. BOSHELL, M.D., and
HEMRAJ B. CHANDALIA, M.D.
Birmingham, Alabama

THE PROBLEM OF OBESITY and diabetes is closely interrelated. The incidence of abnormal glucose tolerance in obesity ranges from 58 to 65 per cent.[1, 2] In our experience, 59 per cent of 231 obese subjects displayed an abnormal glucose tolerance.[3] Conversely, the high incidence of obesity in maturity onset diabetes is also well established. Joslin and co-workers[4] reported that 51 per cent males and 59 per cent of females from a group of 4,596 diabetics were at least 20 per cent overweight. Newburgh and Conn[5] reported that two-thirds of diabetic patients between ages 30 and 55 were obese.

The magnitude of the problem of obesity and diabetes can be recognized from the high incidence of both of these disorders in the American population. The classical survey conducted by Wilkerson and Krall[6] showed the incidence of diabetes to be 1.75 per cent. It is estimated that about the same number of people are latent diabetics in our population. The majority of these diabetics, that is about 90 per cent, are maturity onset, ketoacidosis resistant diabetics and a large proportion of them are overweight. The problem of obesity is even more immense. It is estimated that about 20 per cent of the American population is more than 20 per cent above the estimated body weight.

There is a high incidence of both obesity and diabetes in the American population. The authors show the close interrelationship between obesity and diabetes through biochemical abnormalities common to both and their etiopathology. Dietary therapy, exercise, drug therapy, insulin therapy and the use of anti-obesity drugs are discussed in detail.

The close interrelationship between obesity and diabetes is not purely statistical but is characterized by a few biochemical abnormalities common to both of these clinical disorders. Hyperinsulinemia is characteristic of obesity and is also detected in mild and early diabetes.[7, 8] Not only are the serum insulin levels elevated in obesity but the insulin turnover rate as determined by a constant-rate infusion of labelled insulin is also high in obesity.[9] Furthermore, hyperinsulinemia can be documented in the early stages of diabetes even when the glucose insulin index is taken into account.[3] However, when fasting hyperglycemia appears, insulin deficiency is readily

Presented before the Section on General Practice, 102nd Annual Session, May 13, 1970, at Biloxi.
From the Division of Diabetes and Related Diseases, Department of Medicine, Medical College of Alabama, Birmingham, Ala.

apparent. Some investigators, however, feel that insulin deficiency is the constant feature of all stages of diabetes.[10, 11]

Lipid abnormalities are also observed very frequently in both obesity and diabetes. Type IV hyperlipoproteinemia of Fredrickson is the most frequent type observed in both obesity and diabetes.[12]

The hypothesis of Neel[13] that diabetes is a thrifty geno-type best suited for survival at the time of prolonged starvation again indicates basic similarity of the two disorders. An obese subject, like a diabetic, is more likely to survive during a prolonged fast. In the midst of plenty, however, obesity and diabetes tend to be deleterious to the health of the individual.

ETIOPATHOLOGY

It is clear that diabetes is an inherited disorder although the mode of inheritance is not exactly clear and the environmental factors are of great importance in making the disease clinically manifest. Apart from a few instances of obesity caused by neurological or endocrine diseases, the cause of obesity is unknown. The familial or genetic factors are certainly of some importance as various forms of genetic obesity have been described in mice, rats, Shetland sheepdogs, chickens and hogs.[14, 15] It has been suggested that the obese subjects have a larger number and/or larger size of the adipose tissue cells as compared to the nonobese subjects.[16, 17]

Whatever is the primary etiology, in the final analysis obesity always results from an intake of calories in excess of the calories expended. Many different types of eating patterns have been described in obese subjects. Tepperman,[18] Hollifield and Parson[19] described the "stuff and starve" syndrome in obesity. For example, an obese subject may skip his breakfast, eat a sandwich or nothing at all for lunch and then eat a large dinner and clean out the refrigerator and pantry with "snacking" between dinner and bedtime. This pattern seems to gear the entire enzymatic system of the body for lipogenesis.

Obese as well as diabetic subjects are prone to premature cardiovascular and renal diseases. They also have a higher incidence of osteoarthritis, gout, and chronic obstructive lung disease. They are more prone to accidents than normal weight subjects.

Dietary therapy is the mainstay for treatment of an obese diabetic. A hypocaloric diet calculated to make the patient attain his ideal body weight should be prescribed. The diet should be restricted in concentrated carbohydrates from the standpoint of diabetes. The exact amount of calories to be prescribed is hard to determine. However, a patient can be started on 30 calories/Kg of ideal body weight and further changes made according to the response. This diet should be divided into three principal meals, breakfast, lunch and supper, having the caloric distribution of $\frac{1}{5}$, $\frac{2}{5}$ and $\frac{2}{5}$ of the total calories. If the total caloric content of the diet is over 1,500 calories, a bread and milk or a bread and meat exchange should be removed from the lunch and supper and given as the midafternoon and bedtime feedings. If the total caloric content of the diet is less than 1,500 calories, a skim milk exchange can be removed from the lunch and supper and ingested as the midafternoon and bedtime feedings. The introduction of snacks into the diet makes the distribution of calories more uniform during the day. In addition, in a diabetic on an intermediate acting insulin it prevents the hypoglycemic episodes in the late afternoons and at night. We find that the interval feedings should preferably consist of foods containing proteins, fats and carbohydrates instead of being pure carbohydrate foods like soft drinks, fruit juice, etc. It is very well known that carbohydrates ingested with a mixed diet produce much less elevation of blood glucose than carbohydrates ingested alone.[20]

HYPOCALORIC DIETS

In the past, hypocaloric diets of different compositions have been advocated by various investigators on the basis of the fact that some of these diets produce a disproportionately greater loss of adipose tissue than of lean body mass as compared to other diets.[21, 22] Most of these claims have not been substantiated on careful scrutiny.[23] Most authorities now agree that isocaloric diets of different compositions would produce the same degree of weight loss both qualitatively and quantitatively. However, other considerations, like excessive fluid retention by a high carbohydrate diet, may necessitate prescription of a diet with restricted carbohydrate content.[24]

Not infrequently, obese diabetics have mild hyperglycemia associated with reactive hypoglycemia. These patients also have hyperinsulinemia. The symptoms of reactive hypoglycemia tend to be accentuated when carbohydrates are ingested in large amounts. For the relief of these symptoms the obese diabetic may resort to an excessive food intake. A diabetic diet, however, is always somewhat restricted in carbohydrates and would therefore avoid accentuation of any reactive hypoglycemic symptoms.

The incidence of lipid abnormalities and vascular disease is very high in obesity as well as diabetes. It is very important to restrict the quantity of saturated fatty acids in the diet of an obese diabetic. A diabetic is therefore well advised to derive not more than 35 per cent of his calories from fat and about half of the calories from fat should be derived from the foods rich in polyunsaturated fatty acids. Patients are allowed to use all the liquid oils derived from cottonseed, corn, safflower or sesame seed. In addition, partially hydrogenated margarines which list corn oil, cottonseed oil, safflower oil and sesame oil as the first constituent are recommended.

Occasionally, in an extremely obese mild diabetic patient, we have resorted to a 600 calorie high fat diet. This diet is very simple to follow and there are hardly any chances of errors. In addition, because of its high fat content, this diet has more satiety value than an isocaloric diet of different composition.

TOTAL FASTING

In a grossly obese diabetic, total fasting may be employed to produce fast weight reduction initially and to boost the morale of the patient. The total fast as well as drastic restriction of calories should only be undertaken in patients without any serious cardiovascular or renal problems. During starvation patients may develop hyperuricemia, hypokalemia, acidosis and hypovitaminosis which can be prevented by administration of Allopurinol in those patients who have demonstrated hyperuricemia, administration of a multivitamin preparation and administration of potassium bicarbonate, one gram three times a day. In some obese diabetics, it may be necessary to continue fasting for one day every week to attain continuing weight loss.

Patients on restricted diets and on total or intermittent fasting should have a careful clinical examination to detect any signs of vitamin deficiencies and a hematocrit should be performed periodically. It is advisable for a physician to give a definite diet list to the patient and urge him to abide by it. Patients should be recommended not to skip meals unless as a part of the fasting regimen as this practice encourages poor discipline and usually ends with excessive food intake during other parts of the day. The whole problem centers around reeducation of the patient's dietary habits, that is three meals per day with limited intake on each occasion. The dietary therapy is attended with a very high failure rate which can be reduced, however, by an enthusiastic physician. In case of well-motivated patients, an uninterrupted follow-up will result in some degree of success.

In most patients with minor emotional problems, some degree of environmental manipulation and moral support by the internist suffices to produce a good result. Some patients with serious emotional problems may need expert advice from a psychiatrist. In most young people, creating a sense of pride in their appearance and, in most older people, creating a fear of cardiovascular and renal disease helps make them adhere to the dietary regimen closely. The physician must also possess the proper emotional makeup to treat obesity. He must believe in his program and be prepared to accept relapses.

EXERCISE

Exercise forms an important part of the therapeutic management of an obese diabetic. It should be prescribed within the limitations of the cardiovascular status of the patient. Exercise should supplement the dietary regimen and by no means supplant it. It takes an unusually large amount of exercise to expend a significant number of calories. For example, a twenty-minute walk would be required to expend the calories from one large apple and about 50 minutes of swimming to expend the calories derived from a chicken TV dinner.

With the equivalent amount of weight loss, the patient who has been exercising actually loses a lot more fat than the patient who has not been exercising. The former patient adds additional muscle mass thereby giving the net weight loss equal to the latter patient. It is obvious that it is much more desirable to lose the same amount of weight with regular exercise. Exercise also helps to restore the muscle tone and results in significant lowering of blood glucose levels in diabetics.

DRUG THERAPY

If the diet is unable to achieve normoglycemia, as is true of about half of the obese diabetic group, oral hypoglycemic agents will need to be considered. Most of these diabetics are ketoacidosis resistant and oral hypoglycemic agents are quite safe in these patients. However, marked renal impairment is a distinct contraindication to oral hypoglycemic therapy. In addition, in the presence of severe congestive heart failure, cerebral vascular disease and peripheral neuropathy, oral hypoglycemia agents should be avoided.

Of the two groups of oral hypoglycemic agents, that is the sulfonylurea and the biguanides, the biguanides are preferable in obese diabetics. Biguanides have a distinct anorectic action which

is an additional advantage in these patients. The exact mechanism of action of these drugs is not known, but they probably cause a slight increase in the peripheral utilization of glucose,[25] diminished gluconeogenesis in the liver[26] and diminished absorption of glucose from the intestinal tract.[27] In addition, phenformin causes lowering of serum insulin levels in obese hyperinsulinemic subjects.[28]

Insulin is a very potent lipogenic hormone and, therefore, reduction of insulin levels may help in achieving faster weight reduction or maintaining the weight loss once it has been achieved with the help of a hypocaloric diet. Phenformin has been demonstrated to have a lipid lowering action.[29] It causes a reduction of about 10 to 20 per cent in the cholesterol level and 20 to 40 per cent in the triglyceride level. This may be an additional advantage when the drug is used in the obese diabetic. In addition, the drug has been demonstrated to have some fibrinolytic activity which may be of some help in patients with vascular occlusive disease.[30]

PHENFORMIN

Phenformin is usually employed in the form of a time disintegration capsule. The maximum dose is 300 mg/day. Usually 50 to 150 mg of phenformin are administered in one to two divided dosage. The 25 mg tablet form of phenformin may be particularly helpful if administered before meals in preventing symptoms of reactive hypoglycemia which may be present in some obese diabetics.

The main side effect of phenformin therapy is nausea with a small dose, and vomiting and diarrhea in larger doses. A metallic taste in the mouth may be experienced and may be the forerunner of more serious gastrointestinal symptoms. Phenformin does not produce hypoglycemia in usual therapeutic doses. It has been known to cause elevation of blood lactic acid levels and at times has been incriminated as a contributory factor in the development of lactic acidosis. Usually, however, some other primary cause, for example, severe congestive heart failure, alcohol ingestion, hemorrhage or shock is present to account for the development of the syndrome of lactic acidosis.

The sulfonylurea compounds, that is tolbutamide, chlorpropamide, acetohexamide and tolazamide, are potent hypoglycemic agents which produce hypoglycemia by stimulating secretion of insulin from the pancreatic beta cells. Their main side effects are hypoglycemia, depression of the bone marrow and hepatotoxicity. Occasionally maculopapular or other forms of allergic skin rashes are observed. Hypoglycemia, especially in patients with renal impairment and in elderly debilitated patients, may be observed and can sometimes be quite severe and sustained.

Chlorpropamide in the recommended dosage is considered to be the most potent sulfonylurea. The incidence of primary failure (that is no response within a month of therapy) is observed in 18 to 37 per cent of the patients treated with tolbutamide. About 2.5 to 3 per cent of the patients responding initially to tolbutamide become unresponsive during each month of subsequent therapy and are called secondary failures.[31]

COMBINATION THERAPY

In view of the fact that the sulfonylurea and biguanides have different mechanisms of action, a combination therapy with these agents can achieve control of diabetes in an additional number of patients not controlled by any drug alone. By far the most potent combination available at the present time is Chlorpropamide in dosage of 500 to 750 mg per day with DBI-TD, 150 mg twice a day.

Most of these diabetics are not amenable to successful insulin therapy. Adipose tissue confers upon these people a peculiar property of resistance to insulin. At times these patients are on 100 to 200 units of insulin per day and yet remain uncontrolled. Larger doses of insulin will, however, produce normoglycemia. The insulin resistance observed in these people is not caused by insulin antibodies but is some form of primary tissue resistance.[32] It has been observed that the obese subjects have both hypertrophy and hyperplasia of the adipose tissue cells and the large adipose tissue cells are unresponsive to insulin in vitro. It has also been demonstrated that the reduction of weight in obese subjects diminishes the cell size and restores the insulin sensitivity.[17]

In spite of the above facts, however, those diabetics who have not been controlled on a good dietetic regimen and the oral hypoglycemia agents may need to be put on insulin therapy. If the patient is not grossly overweight, insulin may achieve a fair degree of regulation. There is a tendency for the diabetics on insulin therapy to put on weight, as revealed by the analysis of the data on the patients in the University Group Diabetes Study. The importance of caloric restriction, therefore, cannot be overemphasized.

In the presence of obesity, anorectic agents may need to be used initially to help the patient adhere to the dietetic regimen. The sympa-

thomimetic amines, of which amphetamine sulfate is a prototype, have been used widely. These drugs cause anorexia by stimulating the satiety center in the hypothalamus. In addition, they may produce nervousness and palpitations and should be used very cautiously, if at all, in patients with cardiac and psychiatric disorders. With prolonged usage, a greater degree of tolerance develops to their anorectic action than to the side effects of nervousness, palpitations and insomnia. These drugs should, therefore, be used only for a short period. The ultimate aim is to bring about a permanent change in the food habits of the patient.

The use of thyroid extract to accomplish weight reduction in euthyroid, obese subjects should be strongly deprecated. The usefulness of L-triiodothyronine and human chorionic gonadotropins remains to be fully evaluated.

We have the sincere feeling that future research will document the presence of a "Lipostat" which to a large degree determines the level of obesity for an individual. This is probably set genetically and modified by environmental factors. There are no doubt many factors that carry messages to and from the "Lipostat." Identification of this center and the associated control mechanism should provide us with a much better understanding and, hopefully, a more rational approach to the treatment of obesity. ★★★

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Evaluation of the Dizzy Patient at a University Medical Center

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Dizziness and vertigo are common complaints that almost daily concern many fields of clinical medicine. Symptoms related to the vestibular system may be organic or functional. They may originate from many organs or systems of the body. The specific cause of vertigo is often difficult to discover. The purpose of this paper is to present a discussion of vertigo that will be of value to the general medical profession. Methods of examining the vestibular system will be discussed, including a description of the test facilities available at the University Medical Center.

PATIENTS COMPLAINING of dizziness or vertigo may have a great variety of sensations. Dizziness is a vague term which may be used to describe numerous sensations, such as light-headedness, giddiness, drunkenness, inability to concentrate, general unsteadiness, etc. True vertigo is a subjective sensation of spatial disorientation. It is usually characterized by an illusion of motion either in the patient or in his surroundings. This sensation is not unlike the normal sensation one feels with angular acceleration. Vertigo is characterized objectively by nystagmus and is usually accompanied by vegetative phenomena, such as sweating, pallor, nausea, and vomiting. Only rarely are these accessory vegetative and autonomic reactions severe enough to cause unconsciousness due to hypotension. True vertigo may be seen in many diseases. These may involve either the vestibular labyrinth or the central nervous system and its further peripheral connections for spatial orientation. There are many diseases which affect the nervous system in such a way as to cause vertigo.

The vestibular system is composed of the vestibular labyrinth and a complex interconnection of central and peripheral pathways. The otic labyrinth is the most important sensory apparatus of the vestibular system, but it is not the only sensory source for the system. The vestibular labyrinth is composed of the three semicircular canals, the utricle, and the sacule.

The semicircular canals are primarily concerned with the sensation of rotation, such as from angular acceleration. The utricle and saccule are concerned primarily with the sensations of gravity and linear acceleration. The three semicircular canals of each side lie at right angles to each other. Each one has an enlargement, or ampulla, which contains a sensory apparatus (crista) for the detection of fluid movement. The cristae project into the ampullae and are deflected by the movement of the endolymphatic fluid in the semicircular canals.

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The utricule and saccule have a sensory apparatus (macula) with small particles of sand-like material that transmit to the hair cells the effect of gravity and linear acceleration, much like the true sand in the otocyst of the common crayfish. Impulses from the cristae and maculae are transmitted by the eighth nerve to the five vestibular nuclei in the rhomboid fossa.

The vestibular nuclei communicate with nuclei of the eye muscles by the medial longitudinal fasciculus. Thus, they play a major role in the control of conjugate eye movement. These connections explain the occurrence of nystagmus with labyrinthine stimulation.

Nystagmus is defined as a rhythmical movement of the eyes. When of labyrinthine origin, nystagmus has a fast and a slow component. The vestibular nuclei also convey fibers through the lateral vestibulospinal tract that end in motor neurons of the muscles of the trunk and its extremities. These connections explain the awkward movements of vertiginous patients, especially when at great heights. There are further vestibular connections with the autonomic system and the reticular activating system, which explain the previously mentioned accessory vegetative responses to vertigo, such as pallor, nausea, and vomiting.

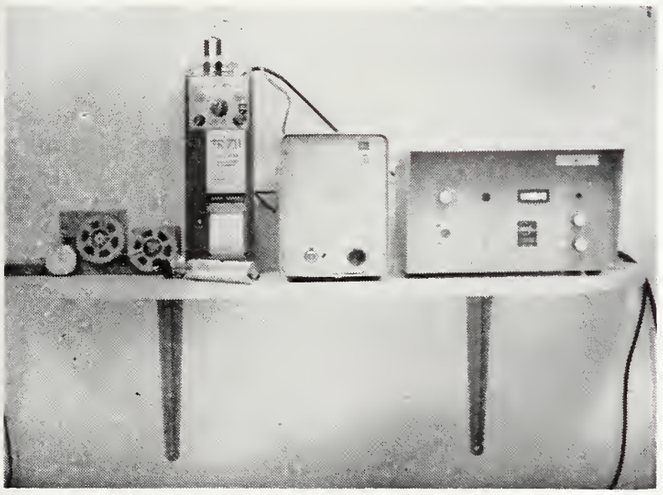


Figure 1. Recording system. DC or AC preamplifiers are used with heat stylus recorders. The use of the DC preamplifier is preferred. At left is a homemade electric winding assembly for rapid rolling of the recording paper.

There are important proprioceptive connections to the vestibular system which aid in spatial orientation. The amount of gravitational pressure on each foot is noted by the vestibular system, and this information is of great assistance in balancing the body. The vestibulocerebellar pathways and other connections account for the important relation of the labyrinth to the cerebellum. There are many more connections in the vestibular system, too numerous to name here, the complexity of which helps to explain the many diseases that may be associated with vertigo.

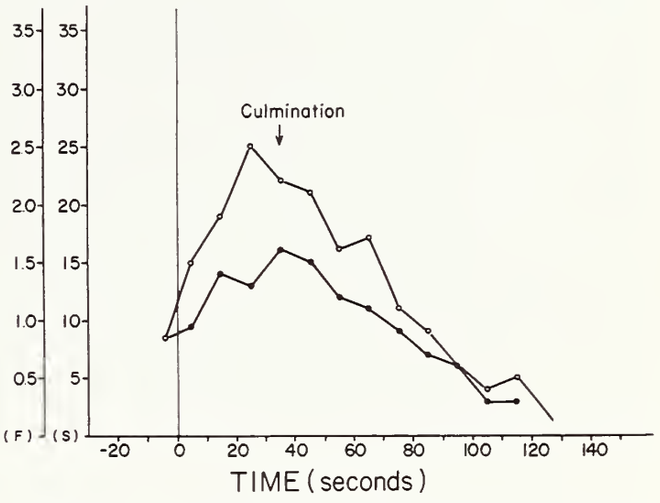


Figure 2. Vestibulogram. Caloric reaction is shown graphically. One ordinate represents the speed (S) in degrees of the slow component and the second the frequency (F) per second of nystagmus. The abscissa indicates the duration of reaction in seconds. The negative time values from –30 to 0 reflect the latency during the 30 seconds of irrigation. The first nystagmus beats may occur before the end of irrigation, a shortened latency indicating increased response. The culmination point is the point of maximum reaction, the point at which both the velocity of the slow component and the nystagmus frequency reach the highest values, usually at 25 per cent of total duration.

The cortical representation of the vestibular system appears to be localized in the temporal or parietal lobe, but has not yet been precisely defined. It is felt that there is no discrete cortical representation, just as with other sensory modalities that are phylogenetically old, such as pain.

Of the reflex pathways named, examination of the vestibulo-ocular reflex is the most important. Nystagmus, as the spontaneous or induced phenomenon, serves to give us this information.

ELECTRONYSTAGMOGRAPHY DEVELOPMENT

The study of a vertiginous patient may be complicated and often needs the assistance of many medical specialties. Until recently, no purely objective tests for evaluating the vestibular system were available. Good methods of stimulating the vestibular system have been used for many years, but the results of these tests could not be recorded objectively. The caloric test of Hallpike and the rotational test of Barany lacked the quantification desired in medical science. Nystagmus, the

most useful parameter for examining vestibular function, was observed in a subjective manner. Only the gross characteristics of nystagmus could be judged and there was no way to observe precise qualities of nystagmus, such as moment of onset, frequency, amplitude, duration, and termination. Very little could be said about the most important parameter of nystagmus, the slow component. Many eye movements were erroneously labeled nystagmus.

In the attempt to achieve an objective vestibular test, another procedure was developed, in which the vestibular system was stimulated by galvanic current. As the current is applied, the patient sways to one side and the amount of sway is measured in degrees. This test has some obvious disadvantages and thus is felt to be inferior to the recording of nystagmus.

Many efforts have been directed toward recording nystagmus. The first methods were the mechanical recording with various recording apparatus attached to the anesthetized cornea. Later, photographic methods of recording nystagmus were used, but proved expensive and impractical. The photoelectric method was introduced in 1951 and has been perfected by Torok. His method (PENG, photoelectric nystagmography) requires the use of goggles containing an infrared photoelectric cell. This senses the movements of the eye by detecting the difference in intensity of the infrared ray reflected from the sclera as compared to the reflected ray from the cornea. PENG has a few disadvantages not found with ENG (electronystagmography).

ENG is based on a principle first noted by Emil du Bois-Reymond in 1849. He discovered the existence of a corneoretinal potential, with the cornea carrying a positive charge in relation to the negative charge of the retina. This biologic dipole was later studied in detail by Mowrer and found to be independent of extraocular muscle activity. After considerable effort, an electronic recorder was finally devised which accurately recorded deflections of the corneoretinal dipole, thus making it possible to obtain an objective recording of nystagmus.

The development of ENG may be compared to the related field of audiology. The audiogram

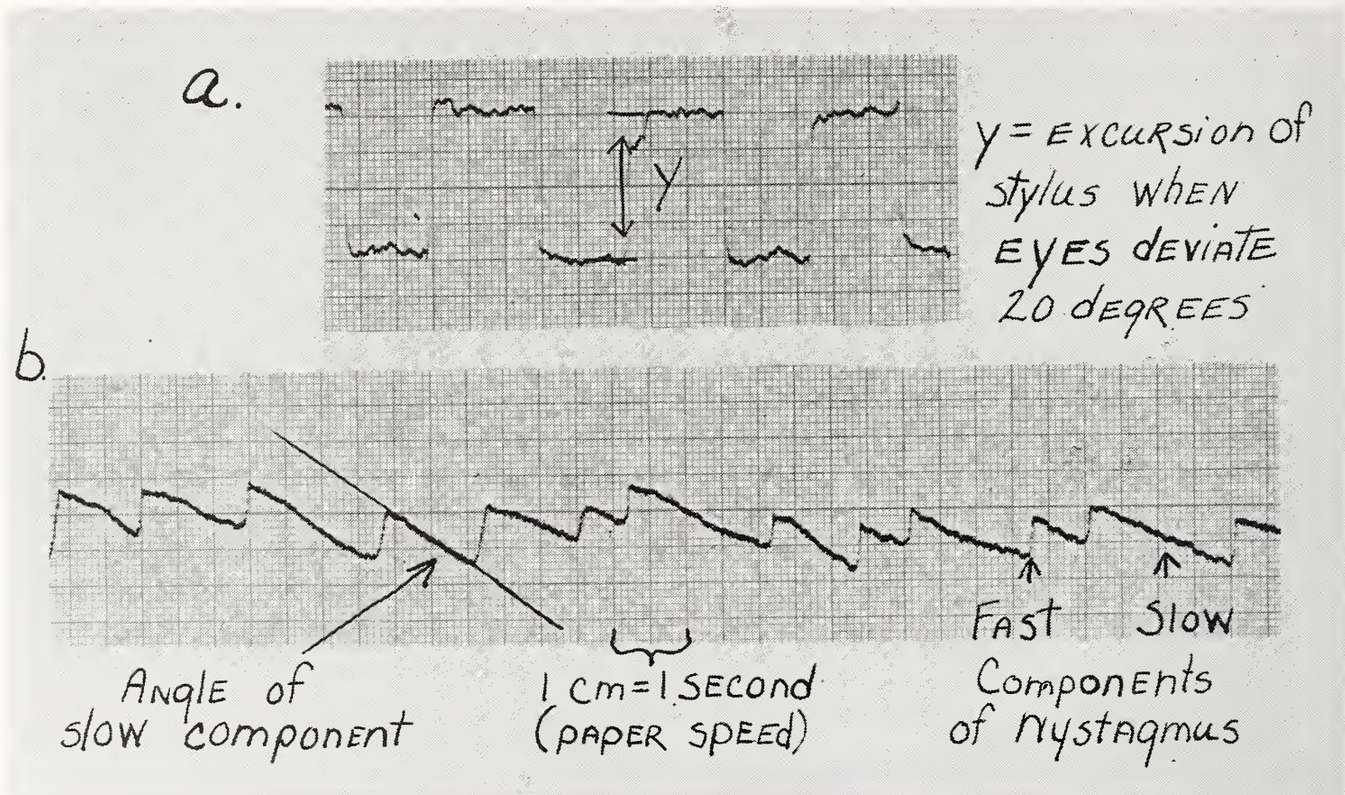


Figure 3. ENG tracing. (a) The system is calibrated by having the patient look 10 degrees to each side (20°) and adjusting the stylus to move 20 mm for this angle. (b) Spontaneous nystagmus to the right. The recording pen has moved in two directions. The fast component of nystagmus is seen as a sharp upward deflection, indicating to the right, and the slow component is the more gradual slope of the pen movement in the downward direction, meaning to the left. Nystagmus is named by its fast component. We are most interested in the characteristics of the slow component which is the primary vestibular response.

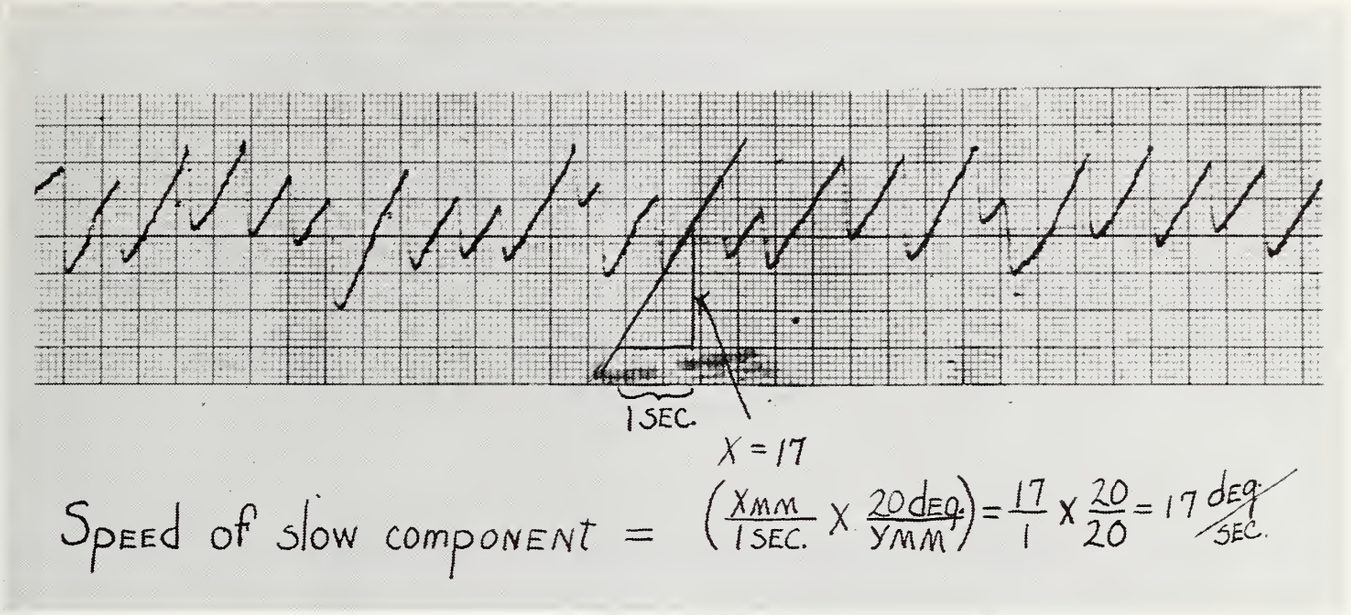


Figure 4. Induced nystagmus to the left. With the information available we are able to calculate the speed of the slow component. (X) represents the distance the eyes have traveled in one second when the paper speed is one cm per second. (Y) in Figure 3a is the excursion of the stylus during calibration.

as a test of the cochlear labyrinth is but a few years older than the ENG. Hearing tests are now taken for granted. We must remember how they focused our attention upon the deafening nature of many industrial noises and encouraged the recent progress in reconstructive ear surgery. The great impact of electronystagmography was soon felt by the advancement of our knowlelge of vestibular function. Aeronautics and space travel have profited greatly from the information obtained as a result of the recent surge in vestibular testing.

THE VESTIBULAR LABORATORY

The basic battery of vestibular tests with ENG available at the University Medical Center includes positional testing, Hallpike caloric stimulation, torsion swing, and electronic rotating chair. Prior to the test a standard history is taken, including information on recent drugs the patient may have taken. Many drugs either create or depress nystagmus and these must be ascertained, especially alcohol and sedatives. If possible, no drugs that might affect the vestibular system should be taken 24 to 48 hours prior to testing. A previously performed audiogram assists in the interpretation of the test.

We use standard electrodes much like the electrodes used for EEG (electroencephalography). One is placed near the outer canthus of each eye, and one is placed on the forehead as a ground electrode. With the electrodes placed in this manner, horizontal nystagmus is recorded. We do not routinely record vertical nystagmus because of the lack of useful information thus obtained, and because vertical nystagmus is spontaneously present in as many as 80 per cent of normal persons.

Electrical deflections of the corneoretinal dipole are modified by a DC preamplifier and recorded with a heat stylus recording device (See Figure 1), much like the readout of an EKG (electrocardiograph). The paper speed is one centimeter per second. We routinely record only the raw nystagmus. A differentiator is available, but no practical advantage can be found in its use in our routine clinical setting. All needed information is obtained by simple manual computation at low cost of material and without loss of efficiency (See Figure 4). It presents a vestibulogram when entered on graph paper (See Figure 2). Computer analysis of averaged signals is being developed by several companies and may soon be available.

TEST PROCEDURE

We record first the presence of spontaneous or positional nystagmus. Subsequently we record the nature of the nystagmus induced by calorization and rotation. Six standard positions are used for the detection of any spontaneous or positional nystagmus. These include: supine, right lateral, left lateral, prone, head hanging, and sitting. Eye movements are calibrated against a known angle of deflection by asking the patient to look back and forth to points 10 degrees on either side of his midline (See Figure 3).

The modified Hallpike caloric test is used to

induce nystagmus (See Figure 4). Each ear is irrigated for 30 seconds with water seven degrees above (44° C.) and seven degrees below (30° C.) body temperature (See Figure 5). Prior to caloric stimulation, the ear canals are examined to determine the presence of cerumen or ear disease. Caloric irrigation is contraindicated in the presence of an ear drum perforation. This stimulation is easily tolerated and usually induces a sensation of subdued vertigo, which we have not found distressing to the patient.

We have two routine methods of inducing nystagmus by rotation. The *torsion swing* is simply a chair that oscillates from right to left and back, inducing alternating per-rotatory nystagmus (See Figure 6). The torsion swing gives valuable information with a minimum of time and effort (See Figure 7).

ROTATION CHAIR

Our second method of inducing nystagmus by rotation is with a programmed electronic *rotation chair* (See Figure 8). The controls may be preset, according to the desired program of rotation. Program variables include the rate of angular acceleration for a preset period of time; the maximum velocity of rotation; the time of rotation at constant velocity; and the rate of angular deceleration (See Figure 9). The routine program of rotation we use is as follows: acceleration at the rate of one degree per second/per second until a velocity of 90 degrees per second is reached; constant velocity of 90 degrees per second maintained for 120 seconds; and then a sudden stop. Rotation is performed in both the clockwise and the counter-clockwise direction while a recording is made of all events. These include the per-rotatory, post-rotatory, and post-post-rotatory nystagmus. The instrument was designed to our specifications and may also be used for centrifugal rotation (See Figure 10).

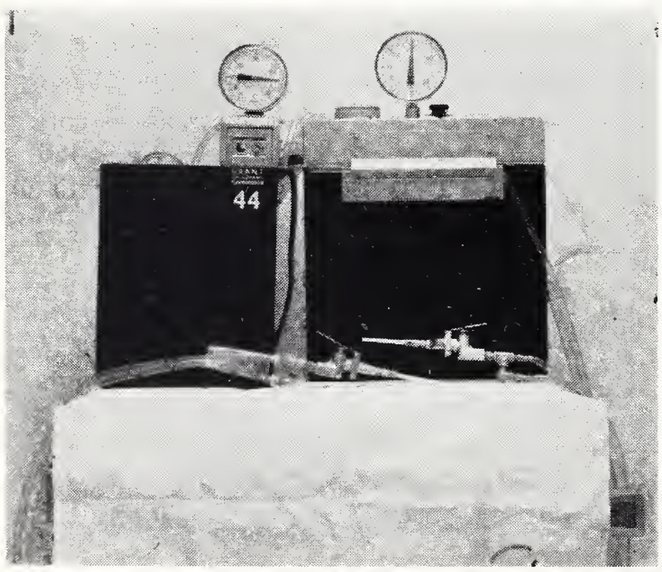


Figure 5. Bithermal irrigation equipment. One water container is set at 30° C. and one at 44° C. A total amount of 300 cc of water is delivered into one ear in 30 seconds through insulated reflux tubing. The two temperatures and two ears require four minaural tests separated by a 5-10 minute rest period.



Figure 6. Torsion swing. A metal torsion bar extending from the top of the chair to the ceiling permits damped oscillation in the horizontal plane. This is a simple economic device for testing the bilateral, per-rotatory acceleration effect on the vestibular system by letting the chair oscillate through a 180 degree arc from right to left and back.

A battery of methods for inducing nystagmus makes the ENG composite and inclusive. Moreover, alternate methods of inducing nystagmus are thus available when a physical handicap

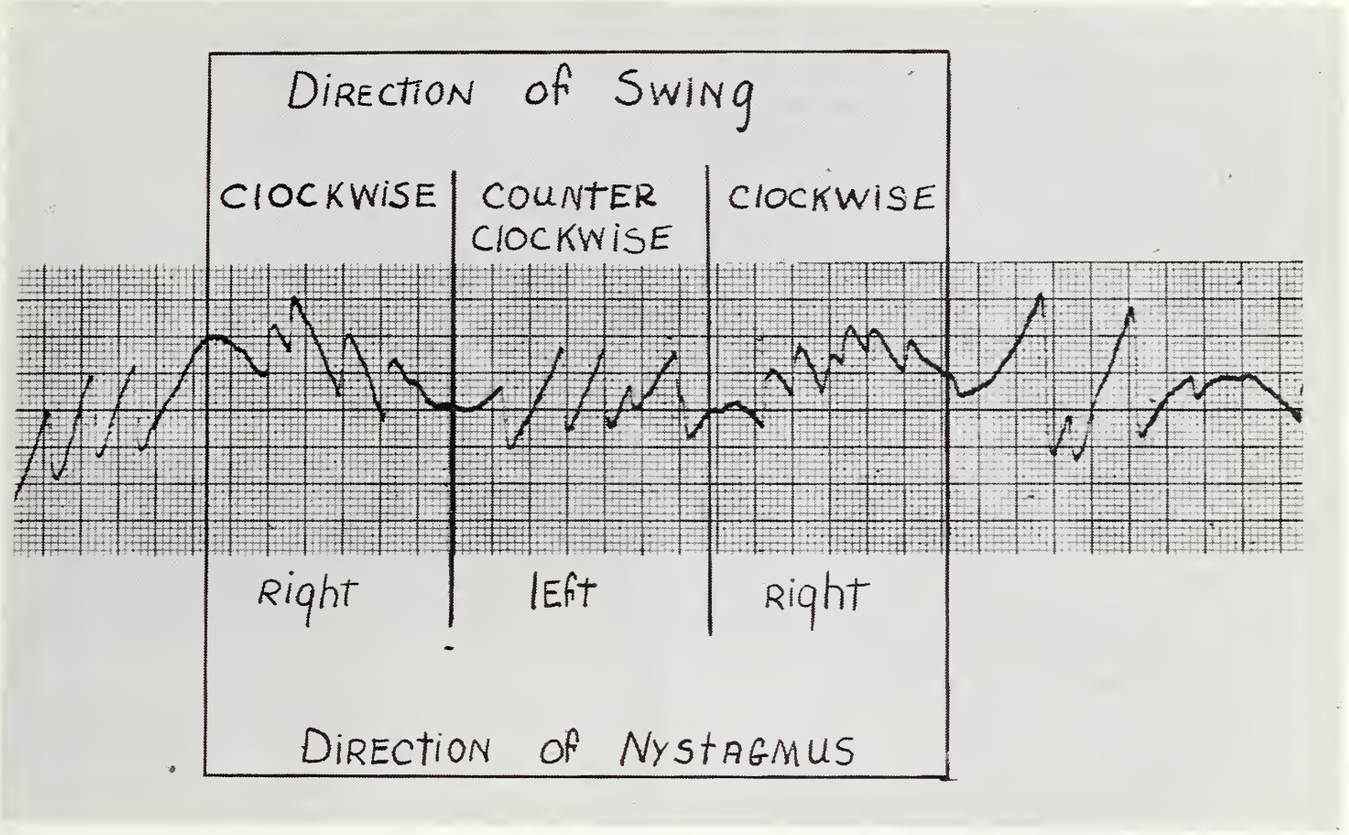


Figure 7. Nystagmus induced by torsion swing. The slow and rapid components of the oscillating eye movements are seen. The nystagmus direction changes as the chair turns back and forth.

such as ear disease or cervical spine disease prevent the completion of a total test battery.

The data derived from the electronystagmograph are combined with information from the history, physical examination, and other diagnostic sources to derive a more specific diagnosis, based primarily on clinical judgment.

VESTIBULAR SYSTEM DISEASES

The symptom of true vertigo must be differentiated from the multitude of vague sensations called dizziness. True vertigo has certain characteristics that help to differentiate between diseases of the peripheral vestibular labyrinth and diseases of the central vestibular pathways.

Peripheral vertigo is usually of sudden onset and is more often associated with nausea, vomiting, and other distressing symptoms. Peripheral vertigo is also commonly associated with lesions in the cochlea, causing an accompanying tinnitus and hearing loss. The spontaneous nystagmus of peripheral vertigo usually remains in the same direction (is direction fixed), and tends to conform with other lateralizing signs, such as a tendency to fall or sway in the direction of the slow component (the Romberg test).

Vertigo of central origin, on the other hand, is of gradual onset, is mild in nature and is less likely to have symptoms that fluctuate in severity. Unlike the acute attacks associated with labyrinthine disease, central vertigo is not commonly accompanied by distressful vegetative signs, such as nausea and vomiting. The nystagmus of central origin is likely to change directions when the patient assumes different positions; it is direction changing.

Of the diseases affecting the peripheral labyrinth, perhaps the most perplexing is **Meniere's disease** due to endolymphatic hydrops. This disease may be conveniently thought of as a "labyrinthine glaucoma." Etiology is at present uncertain. Symptoms include tinnitus, vertigo, and fluctuating hearing loss. The disease usually begins with acute attacks of roaring tinnitus and severe vertigo, associated with marked subjective distress and accessory vegetative signs. Remission after a few days is common and the length of each remission varies greatly, as does the severity of each acute attack. The duration of each attack may vary from a few minutes to several days.

The nystagmus associated with Menière's disease is a horizontal-rotatory type, most frequently away from the affected ear because it is of paralytic type. The hearing loss is of a progressive sensorineural type, worse during an acute attack,

and progressively deteriorating with each attack. This disease usually begins in young adults, who show other signs of vasomotor or emotional instability. The diagnosis is based on history, auditory, and vestibular testing.

Treatment of Menière's disease is both medical and surgical. Medical treatment includes preventive salt-free diet and symptomatic therapy with diuretics, antihistamines, sedatives, vasodilators, etc. Medical destruction of the labyrinth with Streptomycin is being discarded since the advent of a variety of surgical procedures aimed at either selective destruction of the diseased sensory organ, or decompression of the endolymphatic fluid system.

Labyrinthitis is a term that should be limited to true inflammation of the labyrinth, usually of bacterial or viral etiology. As a result of antibiotics and vaccinations against viral diseases, labyrinthitis is less common today. Bacterial labyrinthitis is usually associated with total loss of the functions of hearing and balance on the affected side. Viral infections, such as measles or mumps, more commonly affect only the cochlear division.

A common cause of peripheral vertigo is circulatory disturbance. The internal auditory artery is similar to the central artery of the retina in that it has no collateral circulation. This artery usually arises from the posterior inferior cerebellar artery, which is a main branch from the basilar artery. Vertigo is a common feature of the syndrome of basilar artery insufficiency. Vascular insufficiency affecting the central vestibular pathways in the brainstem may also cause vertigo.

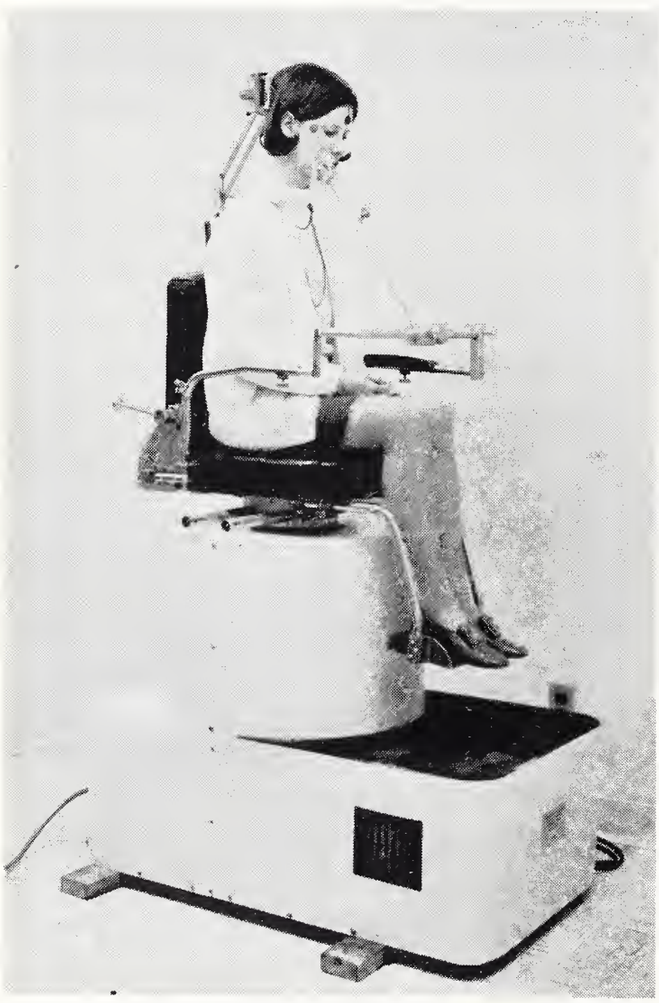


Figure 8. Rotation chair. The chair accelerates until a set velocity is reached, maintains a constant velocity for a set time, and then decelerates, or is suddenly stopped. Nystagmus is recorded throughout the rotation test until the post- (or post-post-) rotatory nystagmus disappears.

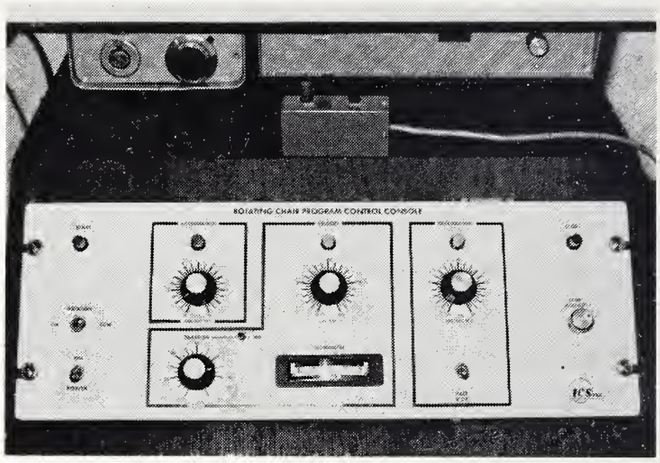


Figure 9. Rotation chair. The desired program of rotation for the chair is easily selected with the aid of a control console: rate and duration of acceleration, duration and maximum speed of constant rotation, rate and duration of deceleration, or moment of sudden stop.

Trauma may cause concussion of the labyrinth or a fracture through the labyrinth (temporal bone fracture), both resulting in vertigo of a peripheral type.

Vestibular neuronitis has become a popular term, describing a disease associated with vertigo of the peripheral type, that is not associated with cochlear symptoms (tinnitus or hearing loss). This relatively benign disease usually follows an upper respiratory infection and is characterized by positional nystagmus. There is also a reduced response to caloric and rotational tests on the involved side. Vestibular neuronitis is at first incapacitating, but full recovery may be expected within a few months.

A long list of drugs may affect the labyrinth. The cochlea, with few exceptions, is affected first by most drugs. Streptomycin, an important ex-

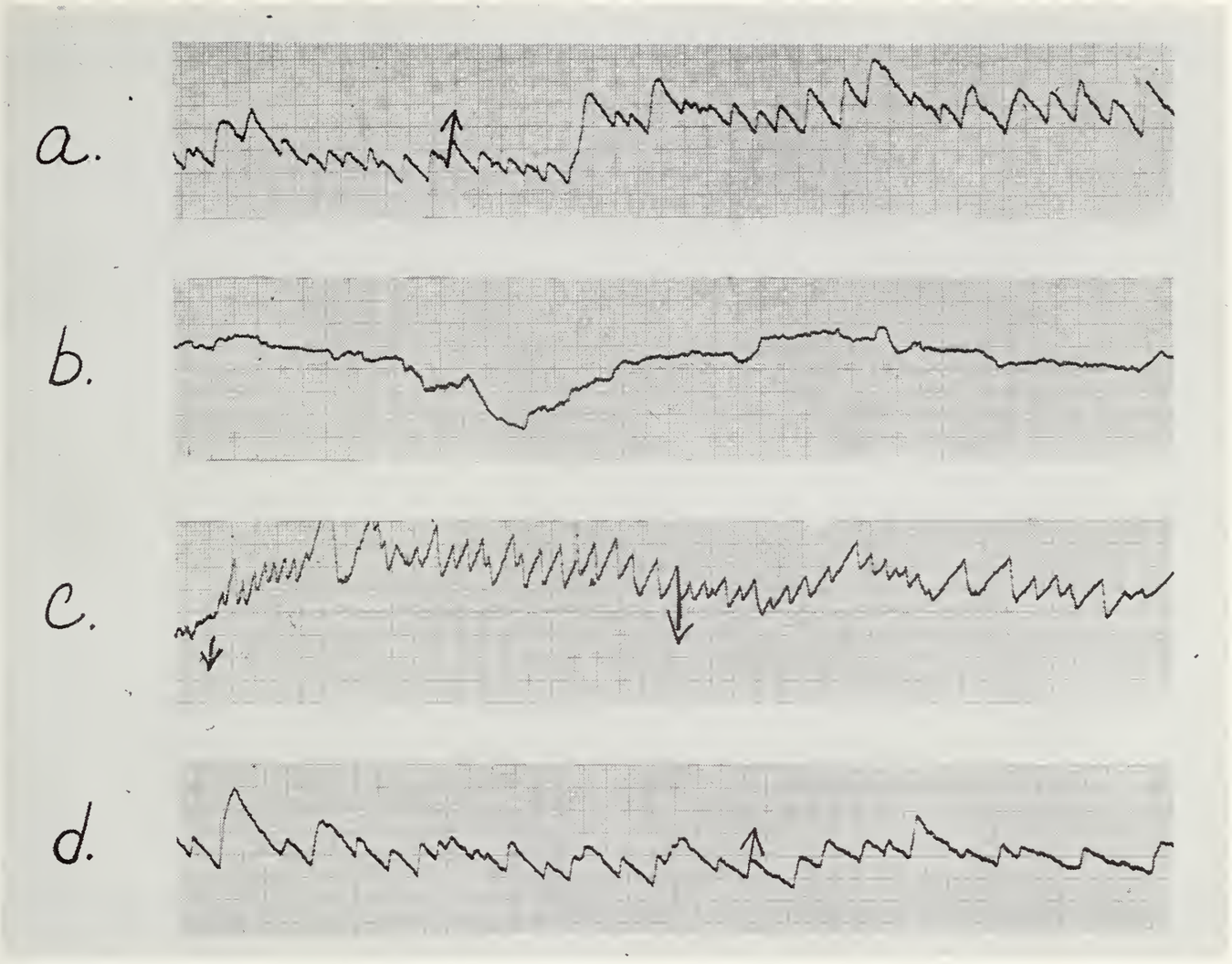


Figure 10. Typical rotation nystagmus. (a) Per-rotatory nystagmus to the right (direction of fast component) during clockwise acceleration (to the right), note the increasing nystagmus magnitudes with increasing acceleration; (b) no nystagmus during constant velocity maintained for two minutes; (c) post-rotatory nystagmus to the left following sudden stop (first arrow), note sudden onset, high frequency and speed, and gradual decline; (d) post-post-rotatory nystagmus to the right (fast) following the disappearance of phase (c).

ception, most often affects the vestibular labyrinth before its affects the cochlea. By the time tinnitus and hearing loss are present, much permanent damage to the hair cells of the cochlear or vestibular labyrinth has already occurred. Kanamycin, Neomycin, Gentamycin, Quinine, and many others are included in the list of toxic drugs.

Other causes of peripheral vertigo include syphilis, herpes zoster oticus, ear surgery, Cogan's syndrome, benign positional vertigo, vertigo due to allergy, and odontogenic vertigo.

Vertigo of central origin may be secondary to tumors, demyelinating diseases, ocular diseases, convulsive disorders, lesions of the cervical spine and foramen magnum, hydrocephalus, cerebellar degeneration, pellagra, hypervitaminosis A, hematopoietic disorders not necessarily associated with vascular insufficiency, migraine, alcohol, drugs, hypoglycemia, and many others. Only a few of the more interesting causes of vertigo of central origin will be mentioned here.

MULTIPLE SCLEROSIS

The vertigo of multiple sclerosis is usually of insidious onset with a peculiar dissociation of vertigo and nystagmus. Nystagmus, often an early sign of this disease, is said to be due to a lesion of the medial longitudinal fasciculus. The ENG recording of a nystagmus of the "bouncing ball" type has been described as typical of multiple sclerosis.

Acoustic neuroma (neurinoma) is a pathologically benign tumor of the vestibular nerve originating within the internal auditory canal. It expands early to the area of the cerebellopontine angle. This common tumor manifests itself by eighth nerve symptoms such as tinnitus, hear-

ing loss, and vertigo. As an acoustic neuroma enlarges in size, it involves next the facial nerve, and later the other cranial nerves arising in the area, the trigeminus in particular. It is a slow growing benign tumor that may be diagnosed early if there is the proper index of suspicion. When this tumor is small, the prognosis with surgery is excellent. As the tumor fills the cerebellopontine angle, the prognosis rapidly becomes worse.

Toxic agents such as alcohol, barbiturates, and certain poisons commonly cause central vertigo, the most common being alcohol. The ENG has provided important practical information on the debilitating and cumulative effects of alcohol on the vestibular system. In the future, aircraft pilots may be required to abstain from alcohol before a flight for much longer than the presently required time of only eight hours.

SUMMARY

The symptoms of dizziness and vertigo are commonly seen in the practice of medicine. The care of these patients is often difficult because of the many diseases associated with these symptoms. The recent development of electronystagmography has greatly increased our knowledge in this field of medicine. In this paper we have correlated the anatomy and physiology of the vestibular system with the increasing knowledge of vestibular diseases. Objective tests of this important sensory system are now available on a clinical basis at the University Medical Center. An advanced vestibular laboratory is described and our routine clinical test is outlined. ★★★

2500 North State Street (39216)

Aided by U.S.P.H.S. Training Grant 2T1 NB 5556-04 from the National Institute of Neurological Diseases and Stroke.

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NOT QUITE THE SAME

Small son to parents bringing home triplets: "We'd better start calling folks. They're gonna be harder to get rid of than them kittens."

Orthopaedic Evaluation of the Newborn

WILLIAM F. OWENS, JR., M.D.
Jackson, Mississippi

This paper considers the physical examination of the newborn for abnormalities of the musculoskeletal system. Birth injuries are discussed as fractures and brachial palsy. The epiphyseal fracture is considered in some detail because of its inherent difficulty in diagnosis. In a discussion of anomalies and developmental abnormalities, the author gives emphasis only to those conditions which are overlooked in the routine examination unless specifically looked for and those which may lead to difficulties if not recognized and treated early.

THE ROUTINE NEONATAL examination for abnormalities falling within the realm of orthopaedics can be considered a search for birth injury and for congenital abnormality of the musculoskeletal system.

Birth injuries are less common with improved obstetrical care, but fractures are still occasionally seen. These are usually of the clavicle, the humerus or femur and the neonatal examination should include a palpation of these long bones for any evidence of deformity, crepitation, swelling and especially for tenderness. Many such fractures will present no striking deformity and the only finding may be tenderness and the failure of the infant to move this limb as the contralateral one. X-ray examination should, of course, always be obtained when there is any clinical evidence of such a problem.

A type of fracture most apt to create a problem in diagnosis is that involving the epiphyseal line. Here the injury is primarily of cartilage rather than bone, and the x-ray findings are subtle. The examiner will be impressed by tenderness, and possibly some edema near the end of a long bone, and this is most apt to be at the shoulder or hip. He is also likely to notice the failure of the infant to move this limb normally.

The x-ray commonly suggests dislocation but this is extremely rare as a birth injury. The epiphysis remains anatomically situated in the joint, but may be separated from the shaft of the bone when there is a fracture through the epiphyseal line. And because the epiphysis has not yet undergone ossification, and is thus radiolucent, it is primarily the abnormal location of the metaphysis with respect to the joint which suggests dislocation. In this injury, however, there is almost invariably a small fragment of the metaphysis which remains attached to the epiphyseal fragment, and can be visualized radiographically as a tiny fragment of bone separated from the metaphysis (See Figure 1).

Treatment of birth fractures is usually quite simple. The clavicle will be practically healed in 10 days and at the most, needs only a small figure-of-eight dressing. Parents are to be reassured that the large callus will be transient. The humerus is best managed by a wrapping which supports the limb and holds it against the chest wall. Care must, of course, be taken to avoid bandaging which might become too tight. This

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injury will show a fairly firm union in about two and a half weeks and the splint can then be discontinued. Bryant's traction, as described in most texts, is the treatment of choice for fractures of the femur. This should not be needed in excess of three weeks when the femur will be expected to show a good early union. Bryant's traction should not be mentioned without a word of caution as to its inherent danger. It should be checked by the physician daily, and by the nursing staff many times each day.

Any consideration of birth injury must include brachial palsy, although, fortunately, this too has become an uncommon entity. The mechanism of injury here is thought to be that of lateral stretching of the neck which might be encountered with difficult delivery of the aftercoming head in a breech presentation, as well as the situation of a baby with large shoulders presenting difficulty in a vertex presentation. The affected limb presents the classical pseudo-paralysis, and it is noted very early to be in a position of adduction and internal rotation. The nerve roots involved and the extent of their damage varies considerably and is difficult to determine in the newborn. In most cases there will be considerable improvement in the first few months and this progress may continue up to two years. Treatment centers around avoidance of contractures and this is done by placing each joint of the limb through a full range of motion several times daily. The mother must understand how to do this and the importance of such care. It is most conveniently accomplished with diaper changes.

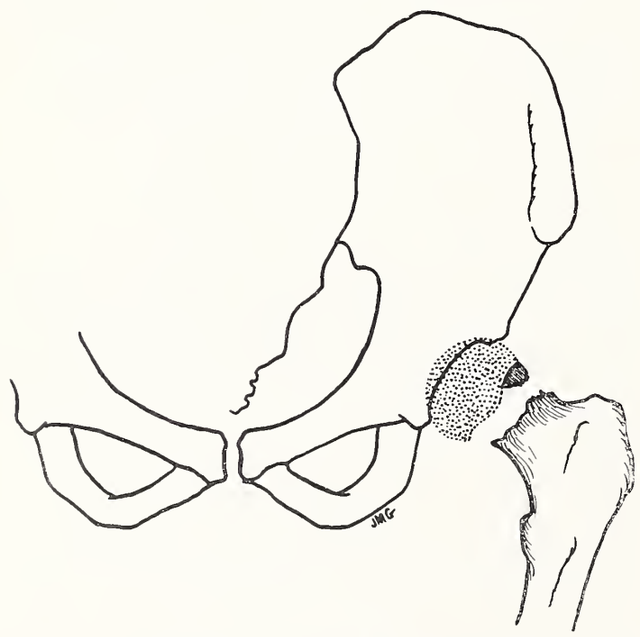


Figure 1. Artist's conception of epiphyseal fracture showing fragment of bone still attached to the radiolucent femoral head.

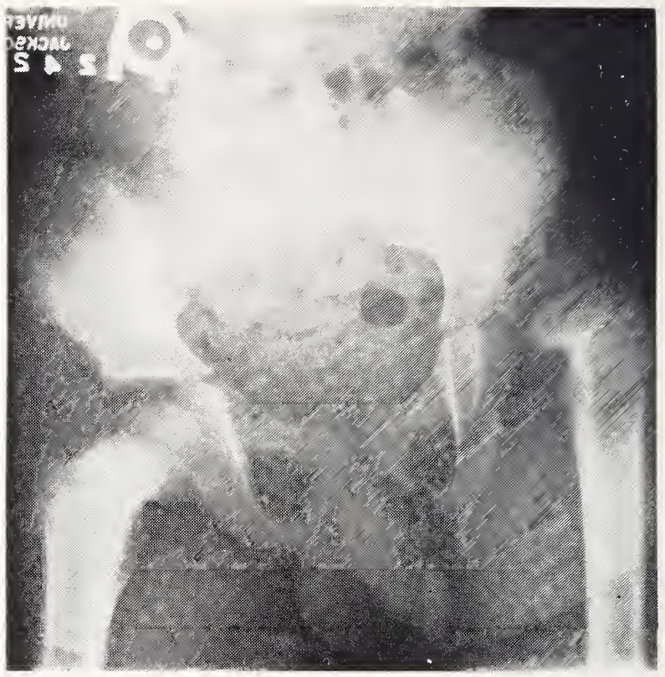


Figure 2. X-rays of a child of three years of age with untreated hip dysplasia showing frank dislocation and marked incongruity of acetabulum and femoral head.

Residual involvement may vary from minimal shoulder girdle paralysis to a flail and anesthetic limb. There is no treatment for the latter extreme, but the deformity common to all is that of an internal rotation and adduction contracture. This may be very significantly improved by an osteotomy of the humerus or muscle transfers at the shoulder when the child is four to six years of age, as reported by Wickstrom and co-workers.[1]

It is only natural that parents may be very alarmed over a birth injury and feel that there has been negligence on the part of the physician. They should be reminded of the inherent difficulties with some deliveries, and the more tragic consequences associated with the hypoxia of undue delay.

Evidence of multiple fractures in the newborn should alert one to the likelihood of Osteogenesis Imperfecta.

It is beyond the scope of this paper to consider all congenital anomalies of the musculoskeletal system. Many of these, such as congenital amputations, syndactylism, supernumerary dig-

its, clubfeet, and meningomyelocele are obvious to cursory examination, and they will not be considered further.

An abnormally large head would cause one to think of hydrocephalus but should prompt the examiner to look for disproportionately small limbs and face which would be highly suggestive of Achondroplasia.

The baby with a lack of mobility of the large joints, especially the elbows and knees, may have Arthrogryposis Multiplex Congenita. The condition is commonly manifested by a rigid and difficult variety of clubfoot and hip dysplasia.

Congenital torticollis should be looked for by examination of cervical spine motion and for evidence of a localized swelling in the sternocleidomastoid muscle, usually near its distal end. When untreated, this condition may lead to a progressive asymmetry in development of the face.

A complete lack of ability to pronate and supinate the forearm may be found by x-ray to be due to a synostosis between the proximal radius and ulna. This uncommon condition is not often diagnosed until the child is several years old, but could be detected early by the routine testing of the forearm rotation.

A newborn with marked generalized loss of muscle tone would suggest Amyotonia Congenita.



Figure 3. Photograph of the essential maneuver in examination of the hips in the newborn. Note that full abduction of the flexed hip is easily accomplished in a baby with normal hips.

Examination for congenital hip dysplasia is perhaps the most important part of the routine orthopaedic evaluation of the newborn. This condition is much more common in females and in some areas is reported greater in frequency than 1 in 1,000 live births. In over half the cases it is bilateral.



Figure 4. X-rays of the pelvis in a newborn with bilateral congenital hip dysplasia. The horizontal and perpendicular lines create four quadrants and show the femoral head to be definitely dislocated on the left, and probably so on the right.

In its simplest analysis, congenital hip dysplasia is a retarded development of all the structures which constitute the hip joint. The acetabulum is shallow, the upper femoral epiphysis is relatively small, the adductor musculature is contracted and there is a delay in the ossification of the cartilage in the area. This complex accounts for a relative instability of the hip joint, and the ease with which many become subluxed or frankly dislocated. And following this event, the growth and development of the femoral head relative to the acetabulum and vice versa, becomes increasingly abnormal, and the chances for a normal hip joint diminish as the condition persists unrecognized and untreated (See Figure 2).

The basic maneuver for determining the condition is that of abducting the flexed hips (See Figure 3). Normally the adductors allow the thighs to be simultaneously abducted to, or almost to, the level of the examining table. This degree of passive motion is restricted by tight adductor muscles in the baby with congenital hip dysplasia,

and where the hip is subluxing or dislocating, a palpable and audible click may be appreciated as the femoral head moves back and forth over the rim of the acetabulum. This finding is considered highly diagnostic. In the dislocated hip there will be shortening of the thigh and in many infants, asymmetry of the skin folds. The latter finding is not uncommon however, in the normal baby.

X-RAY EXAMINATION

When physical findings suggest the possibility of hip dysplasia, x-ray examination must always be performed. Because the upper femoral epiphysis is never ossified in the early months of life, x-ray interpretation requires careful consideration of the location of the femoral head. To better identify the location, lines are drawn on the x-ray so as to establish four quadrants at each hip. This is done by a horizontal line drawn through the center of the acetabulum and a vertical one dropped through the lateral edge of the roof of the acetabulum (See Figure 4). The upper femoral epiphysis should then lie medial to the vertical line and inferior to the horizontal line. If it is not so situated it must be dislocated. The unossified epiphysis must be visualized in the examiner's "mind's eye" just superior to the proximal end of the femoral neck.

Treatment of the condition when diagnosed early is usually a matter of simply maintaining the abducted position and this can be done for at least the first six to eight weeks by wearing extra diapers. By age two months, a pillow splint will be needed. Treatment is commonly required for four to eight months and requires serial x-ray examination. In the occasional case where there is gross instability, a spica cast may be indicated for more certain and rigid immobilization.

When the condition is not appreciated during the first few months of life, then the treatment becomes more difficult and the ultimate prognosis worse. The object of treatment is to reduce the



Figure 5. The physiological position of adduction, flexion and external rotation of the lower extremities of the newborn and the resulting presentation of the medial aspect of the limb to the examiner.



Figure 6. The knees are being held so as to view the legs anteriorly and evaluate for tibial torsion and foot deformity. In this case, the internal tibial torsion is demonstrated by the ankles being directed medially as the proximal tibia faces anteriorly.

hip and maintain reduction. In the older baby this will require traction, and open reduction if the traction alone is unsuccessful. Forceful manipulation is mentioned only to be condemned for it commonly results in avascular necrosis of the femoral head.

When the hip is not reduced or when it remains dislocated during the critical early months of life when there is greater potential for development of a normal hip, then the ultimate result will be degenerative arthritis associated with the lack of congruity of femoral head and acetabulum or with the persistent dislocation as the case may be.



Figure 7. Photograph of a baby eight months of age showing a striking metatarsus varus. This patient had been unsuccessful treated with a Dennis-Browne Splint.

The next two entities will be considered together because they are so commonly seen together and the management is so similar. Metatarsus varus, or turning in of the forefoot, is a rather frequent condition and thought by some to be more common in recent years.

INTERNAL TIBIAL TORSION

Internal tibial torsion is seen as an independent finding but will most often be accompanied by metatarsus varus. The condition may be bilateral but often times one foot will be in a position of calcaneovalgus, or turning up and out, and the two legs then give the appearance of being "wind blown."

In order to appreciate the presence and degree of tibial torsion the examiner must view the limb anteriorly. And when seen in physiological position, the legs are flexed and in external rotation



Figure 8. Corrective casts on the patient shown in Figure 7 showing the forefoot being held in a corrected position.

and the examiner is actually looking at the medial aspect of the legs (See Figure 5). When the flexed knees are brought together so as to actually be seen anteriorly (See Figure 6) then the ankles should be directed straight forward. But when there is an internal tibial torsion, the ankles will be directed medially and the internal rotation deformity of the tibia can be appreciated.

The feet are also to be observed with the legs in neutral position as described, and examined specifically for turning in of the forefoot (See Figure 7). When the foot is gently stimulated it will usually move toward the stimulus, not unlike the suck reflex, and this enables the examiner to test for the range of active inversion and eversion. The forefoot turns medially in metatarsus varus and the baby commonly does not use the peroneal muscles, or evertors, when stimulated.

Although it is quite true that many cases of mild internal tibial torsion and metatarsus varus correct spontaneously with growth and development, there is no certain way to predict which ones will correct and which will not. This means

all of the more severe cases should be treated, and the less severe ones should at least be observed carefully and regularly and treated when it becomes evident that spontaneous correction will not occur.



Figure 9. Picture of a mild calcaneovalgus foot on the right in a newborn. The condition does not ordinarily require treatment and the parents should be reassured that it is usually self correcting.

Shoes set in external rotation on a Dennis-Browne splint have long been used for treatment of these problems. I personally feel that this technique is best for maintenance of the corrected problem, that is, to prevent recurrence. And correction itself is far better accomplished through application of plaster casts (See Figure 8). The casts are changed every one to three or four weeks, depending on the age of the baby, and this is continued until there has been slight overcorrection of the problem. Close follow-up is then required because recurrence is common.

THE CALCANEOVALGUS FOOT

The calcaneovalgus foot (See Figure 9), as the name implies, turns up and out, and is a manifestation of the position in utero. Occasionally an identation may be noted on the anterolateral aspect of the distal leg where the dorsum of the foot was in contact. This position will be accompanied by a relative shortening of the toe extensor and ankle dorsiflexion muscles, and a lengthened heel cord. This problem can be expected to correct spontaneously and should not be the subject of special treatment. When treated by shoes, braces or casts, the opposite deformity, or metatarsus varus, may be created. ★★★

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NEW ANGLE

The ecological revision is: An apple a day keeps the doctor away—but not unless you wash off the spray!

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Radiologic Seminar CVII
The Eisenmenger Complex

F. J. HAMERNIK, M.D.
Vicksburg, Mississippi

THE EISENMENGER COMPLEX is a congenital anomaly very similar to the Tetralogy of Fallot and is characterized by: (1) interventricular septal defect; (2) right sided aorta; (3) hypertrophy of the right ventricle; and (4) a lack of the pulmonary stenosis as seen in the Tetralogy of Fallot. Sometimes an associated patent ductus arteriosus is present. Because the stenosis is absent, there is a characteristic "hilar dance" of the enlarged pulmonary vessels.

Upon catheterization, the pulmonary artery and right ventricle pressures are observed to be increased because of the interventricular septal defect. With age, the septal defect increases in size and eventually the pulmonary pressure approaches that of the aorta. Cyanosis occurs later than in the Tetralogy of Fallot.

In figure 1 the P. A. view of the chest shows increased pulmonary hilar shadows, patent ductus arteriosus and hypertrophy of the right ventricle. A right-sided aorta is not present in this case.

In figure 2 the lateral view of the chest shows the prominent hilar shadows, vascular markings in the lungs, the enlarged pulmonary conus without stenosis, and the right heart enlargement.

The clinical findings of the Eisenmenger Complex vary from moderate to severe with exertion. If there is an associated patent ductus or an



Figure 1. P. A. view of the chest.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Vicksburg Hospital.

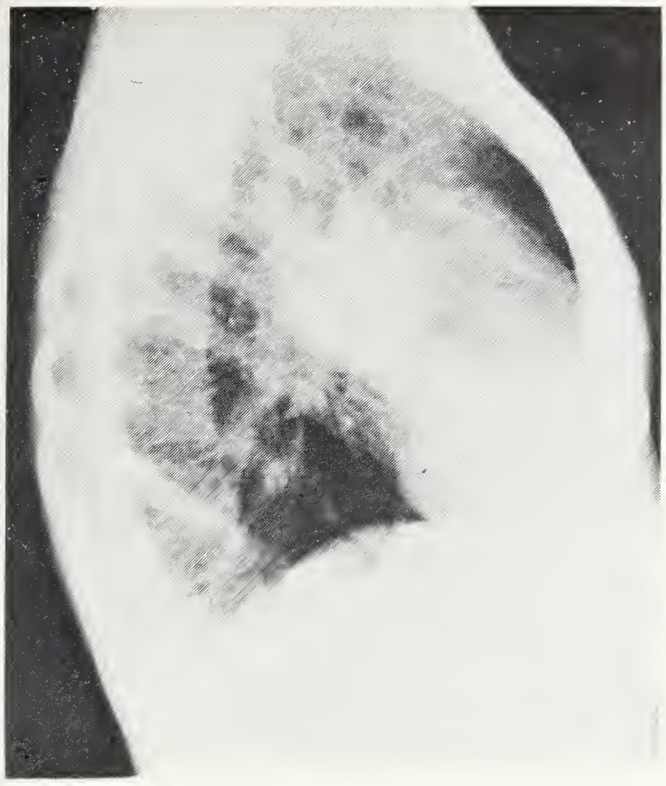


Figure 2. Lateral view of the chest.

atrial septal defect, there may be clubbing of the fingers, or polycythemia.

A systolic murmur can usually be heard along the left sternal border and of course a loud murmur is heard if there is a patent ductus.

ECG findings show right ventricular hypertrophy with peaked P waves.

Cardiac catheterization and dye dilution studies may be necessary to localize the site of abnormality.

Prognosis is poor and the disease is usually fatal by age 30 from heart failure, vascular thrombosis or endocarditis. No treatment is effective. ★★★

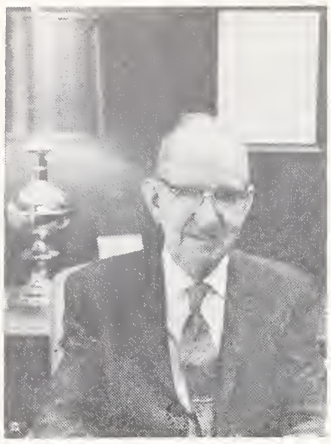
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FREUDIAN SLIP

One the proofreader missed: "If we could send young people abroad to stud and perform, they'd do more in goodwill for this country than a million dollars in aid."



The President Speaking

'A Matter of Stewardship'

PAUL B. BRUMBY, M.D.
Lexington, Mississippi

THIS IS THE MONTH of accountability for the officers of our society. This accountability lays a heavy hand on those involved in the constant attempt to keep medical care and its delivery in the hands of the private practitioner. The past year has been dominated by the socioeconomics of a new era, an era distrusted by the whole of the medical profession. It has brought many problems that beg of a solution.

The concept of medical foundations which are servants of the medical societies brings a new and a varied approach to the attempt of retaining some of our traditional ideas. There is need for immediate study of the whole range of foundations which are now being implemented throughout our nation. We are fortunate in having our Peer Review Committee, in having our office building, our hardware, and the personnel with their expertise. We can convert quickly to HEW approved foundations.

Our malpractice problems of last year are somewhat abated, and our collective image has improved. We received a resolution from the Speaker and the House of Representatives of the state legislature thanking us for our EMCU and the services rendered to individuals and committees of the House.

To me the outstanding feature of the Mississippi State Medical Association has been the dedication and devotion of many individual physicians who have spent limitless days and traveled limitless miles to further the welfare of the whole of the profession. Those who spent time and effort and money came from every part of the state, and they have proven their singular devotion to this society.

The greatest thrill of the year and the greatest compensation of a lifetime to me has been to know so many physicians and their wives. Your warm reception Lynda and I accepted with gratitude and as your gesture of appreciation to the Mississippi State Medical Association. We hope we have conveyed our sincere appreciation to each of you for allowing us the honor, the great honor, of having the privilege of serving. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 5

MAY 1971

EDITORIALS

The Internship and the Continuum of Graduate Medical Education

I

THE CONTINUUM is the thing in medical education, and the bits and pieces have got to go. So said the House of Delegates of the American Medical Association at Chicago last June when the policy on integrating the internship with residency training was adopted. The idea is to make a cable of continuity from the threads which run from undergraduate years through the winning of the undifferentiated M.D. degree into postgraduate training.

When the policy action was taken to weed out "free-standing internships," there was a ripple of academic panic evident, chiefly because of misunderstanding. The expression was interpreted by some to mean that rotating internships were being abolished. There were those who thought it meant that intern programs in hospitals without medical school affiliations were to be discontinued. A few believed that all internships were being abolished.

The House action did not abolish the most familiar institution in the medical education process. It does require that the internship be made an integral part of the total graduate medical training program, thereby enhancing its value to the trainee. Moreover, the deadlines for implementation were fixed far enough into the future to permit training institutions to restructure programs and to minimize dislocations.

If the awarding of the undifferentiated M.D. degree is, as the Millis Commission has said, the midpoint in the medical education process, then the time has passed to do exactly what AMA and the Association of American Medical Colleges are doing: Underscoring the quality of the graduate training segment and making the continuum the thing, because no competent practitioner in the eighth decade of the 20th century can be made from bits and pieces.

II

The easiest way to understand what the educators and delegates did is to define the terms which they employ. "Free-standing internships" are those programs not related to residency training, whether in the same institution with both programs or not. An example of a free-standing internship is one offered in a hospital that has no residency programs and no relationship or affiliation with any other graduate training source.

Still another example of the free-standing internship is one in a major training institution which has approved residencies but which offers the internship as a discrete educational experience with no indication of coordination with the residencies.

The action in June 1970 created two deadlines for training institutions. The first is coming up

fast on July 1, 1971, from and after which the AMA Council on Medical Education will consider that the first year of any approved residency, including family practice, is the equivalent of an internship program now bearing AMA approval.

The 1971 deadline isn't really a doomsday brink at all, because it has as its purpose making it possible for undergraduates to obtain some internship or graduate experience during the fourth year of medical school. And the schools have been moving toward this segment of the continuum rapidly. It accelerates the training process, too, and this is sorely needed. In practical application, the brand new M.D. goes directly into his residency training, and this is what the second deadline, July 1, 1975, is all about.

This is a doomsday brink, for thereafter, the bits and pieces of discrete, disconnected graduate training are out for good. Full implementation of the continuum policy must have been achieved by then. In addition to academic considerations, some legislative endeavor will be on the agenda in many states where the internship is bound up in licensure requirements of outmoded statutes.

III

The phase-out of the no-connection, no-continuum internship will be rapid, because AMA will approve none after next July 1 unless the applicant institution can demonstrate that its program will be crocheted into somebody's approved residency program in some institution bearing American board and AMA approval.

Now a debater so inclined could retort that we've finally done it and created a system which will produce only specialists over a rather considerable period of time. This is untrue on two important accounts contradictory to such argument:

First, there is nobody around today who says that a mere year of graduate training after award of the M.D. is sufficient. There are 20 major specialty boards, and the newest, the American Board of Family Practice, will require three years. So it isn't a matter of creating a fragmented profession but rather one of getting the training together in a logical manner. There is simply too much to learn in less time.

Second, it is the only rational way to accelerate the graduate education process. If a year has got to come off somewhere, then where better than at the midpoint of the continuum of training? President Walter C. Bornemeier said in his AMA inaugural address that physician shortages can best be met by accelerating the training time, and his goal is the M.D. six years after high school graduation. With imagination on the part of the educators—and they have a lot of it—this may become a reality in a decade.

There is also a more subtle rationale in this move related to the trainees themselves as well as to the institutions. AMA emphasizes the necessity of solid grounding in the broad fields of medicine, surgery, pediatrics, psychiatry, family practice, and pathology early in the unified graduate medical education process. In fact, the AMA Council on Medical Education has recognized the value of a basic two years in beginning the process of making a well-trained physician.

While the basic two years provides this solid grounding, permits the trainee physician time in committing himself to a career goal, and facilitates better lateral mobility in the education process, there is also a danger. Of late, there is a strong trend among students toward early specialty branching, even within the undergraduate program. AMA clearly recognizes the potential conflict between the desire to shorten the total graduate education process and the need to underpin the training with depth and breadth.

IV

There are exciting promising years ahead in medical education for everybody from the youngster aspiring to be a physician to the established practitioner. By no means will American medicine's total and best effort be concentrated alone



"But, which one *is having a baby?"*

on the formal graduate training curriculum. The continuum goes farther than that.

Continuing medical education has arrived on the scene as a going concern and a necessary one, too. We cannot maintain or raise our quality goals without it. No longer are the regular reading of the journals, the county medical society, and the state seminar sufficient. The knowledge explosion is a geometric chain reaction in the arithmetic life span of the profession. It is now urgently necessary that little sabbaticals be scheduled each and every year when the practitioner goes to the major training center, puts on the long white coat, and addresses himself seriously to catching up with his amazing times.

At the risk of having some think that the sledge hammer is being swung at the icons of medical tradition, the day of the conventional medical meeting as an educational medium may well be numbered and found wanting. There will always, let it be hoped, be regular meetings in medical organization, but there is every indication that the scientific session in the four-day convention may give way to the socioeconomic seminar as the serious learning process logically moves to the medical center campus.

This is what the internship issue portends, and it appears on the complex graduate education scene as a progressive innovation toward better trained physicians who will deliver higher quality medical care.—R.B.K.

The Shabby Conduct of Sen. Kennedy

Just about the biggest domestic issue before the 92nd Congress is health care financing and delivery. Dozens of bills have poured into the hoppers on both sides of the Capitol. Fully half of the 535 senators and representatives have appended their names to one to 50 such proposals. Committees are holding hearing all over the place.

The two big ones, Sen. Edward M. Kennedy's (D., Mass.) preposterous $77 billion "health security package" and AMA's Medicredit butted heads in hearings before—you guessed it—Sen. Kennedy's subcommittee this spring. The most newsworthy item to emerge from this hearing was the incredible conduct of the subcommittee chairman.

Opening the hearings, Sen. Kennedy said in part that "for more than four frustrating decades, America has been able to find neither the will nor the way to safeguard its most cherished national resource—the good health of its people. After 40 years, the providers and financers (sic) of health care in America have established a dismal record of performance—a record characterized by inequity, inefficiency, ineffectiveness, inflation and worst of all, by inhumanity. Too often the system is an obstacle course for the consumer, not a path to better health.

"Frequently in America," the senator continued, "the best medical care is found side by side with some of the worst medical care anywhere in the world. *Not even the affluent patients in our society have confidence that their diagnoses are accurate or that their treatments are appropriate* (Italics added). For millions of our citizens, the quality of care is so poor that they may easily find themselves worse off because of their contract with the system."

This brand of invective, tissues of half-truths, and some patent falsehoods would be much more at home in the ghetto gutters of Boston than in the halls of the United States Senate. The mere utterance of such abusive, tasteless language is an affront to the dignity of the senate and an insult to that vast majority of honorable individuals who form that distinguished body. It was also insulting to the witnesses representing American medicine who were the targets and dubious beneficiaries of the blast, sitting before the subcommittee at the witness table on invitation.

We should not, however, permit astonishment to pervade our disgust. This alumnus of Harvard who experienced some problems with examinations and academic independence generally expected of students may judge society from a perspective somewhat bereft of probity.

On the other hand, he may feel animosity for the scarcity of medical care on a summer evening at Chappaquiddick up on the Massachusetts Cape a couple of years ago. It is evident that he was poorly attended at the time.

Then again, he may be plain sore about the drubbing given him by his Democrat colleagues when they decided that they needed a new whip or assistant majority leader in the 92nd Congress. It is only reasonable to conclude that if you have a burr under your saddle blanket, neither you nor your horse is comfortable.

But this wasn't all the senator had to say on this occasion. He went on to conclude that there is twice as much surgery in the United States than in Great Britain because we have twice as many surgeons. He suggested that we have a Parkinson's Law for surgery which says that the amount of surgery performed in America ex-

pands to fill the time of the surgeons available to do it.

His peroration came when he said that "everywhere I travel in America, I meet people concerned with the high costs and low accessibility and the poor quality of health care. 'Don't get sick in America,' we are told, and 200 million citizens say amen."

This is shabby and reprehensible conduct for a United States senator, but it may serve a useful purpose after all. These are the words of the man who says he has the answers to problems of health care delivery and financing. Can you possibly imagine what he would say if he lived at the other end of Pennsylvania Ave.? Let us fervently hope that the latter is an eventuality with which our nation is never confronted.—R.B.K.

New Help for Students from AMA-ERF

The American Medical Education and Research Foundation, AMA-ERF to most of us, has done a remarkably fine job for medical education in its brief life of two decades. Now it is about to do even better.

Dr. John M. Chenault of Alabama, chairman of the AMA-ERF board of directors and an AMA trustee, has announced that interest-free loans will be made to deserving needy students. The Foundation will solicit funds with which to make the interest payments in behalf of the trainee, since the bankers can make no distinction among borrowers.

This bold and imaginative move characterizes the spirit of AMA-ERF. Between annual fund-raising campaigns, many of us tend to forget this work, let alone the need for it. AMA-ERF is purely voluntary, and because the state medical associations and AMA perform its administrative tasks, 100 cents out of every dollar given go to medical education. Even to the specific school and purpose of the donor, if so desired.

We also tend to downplay the value of the Foundation by thinking in terms of small gifts. Not so, really, for in 20 years, it has guaranteed $48.5 million for medical education and post-graduate training to 43,600 students, interns, and residents. The Foundation has given $19 million to the nation's medical schools, not a great deal of money as medical education goes, but enough to help considerably because it may be used in any manner the dean and his associates see fit. This makes an AMA-ERF dollar the equivalent of two or three earmarked and restricted tax dollars, the deans say.

The Foundation now lends up to $1,500 each year to freshman and sophomore medical students and up to $4,500 per year during the junior and senior terms. The student has 10 years from graduation to repay. The new interest-free aspect will apply to the years before the M.D. degree is won. From that point on, the new physician would be charged interest.

AMA-ERF is also encouraging the medical schools to establish scholarships for needy but capable medical students who qualify for the interest-free money. This aid would extend only during the first two years but long enough to assure firm footing in the task of becoming a physician.

The 1971 campaign will begin next fall, and with these facts in mind, perhaps more physicians, Auxiliary members and medical societies will respond as never before in this worthy endeavor.—R.B.K.



All right, all right, I'll fix the air conditioner!"

Ecological Purity in Rural Revitalization

"Seventy per cent of the American people live on only 1 per cent of the land of the United States. . . ."

This startling fact was stated in a speech by Sen. John McClellan (D., Ark.) recently when he made a few points on the environment and pollution which are normally overlooked. The respected senator said that high concentration of population makes pollution problems, critical housing circumstances, and even crime inevitable.

The environmentalists or "ecopro's" as the professional ecologists are becoming known are divided into many shades, degrees, camps, and factions. Some are anti-technology, a breed of environmental know-nothings who probably oppose garlic bread as a potential air pollutant. This segment would literally sacrifice any technological progress in the name of environmental purity.

The more serious and practical strain are deeply and properly concerned with preventable pollution, albeit eliminated only with the outlay of such huge sums of money as to drive the source out of the economy. The best of the lot are those attacking the problems of pollution on a practical, can-do basis of getting little things done in the hope and expectation of moving on with progress.

Sen. McClellan is one of the practical statesmen among us. He is a leader in co-sponsoring a bill in the senate to revitalize rural America by making it livable, profitable in terms of earning a living, and attractive despite "disadvantages" of nonurbanization. He can shake you up with his array of facts and figures on the decaying cities as with his 70 per cent of the population on 1 per cent of the land mass.

Population dispersal can only be beneficial, as the senator readily recognizes. But in the spirit of freedom, he foresees no forced exodus from the cities. Rather, he is proposing controlled tax incentives to get folks back to the clear, open spaces.

This is exactly what the state medical association's House of Delegates said in 1970 when the resolution urging tax incentives for the rural practitioner was adopted. It just makes good sense to thin out the messy mass we call cities and to realize that this will assist in our goal to lessen pollution to say nothing of crime and undesirable living conditions.—R.B.K.

NEW MEMBERS

Allen, Raymond Archie, Jackson. Born Lyman, Utah, Nov. 6, 1921; M.D. University of Louisville School of Medicine, Louisville, Ky., 1946; interned New York City Hospital April 1, 1946-June 30, 1947; pathology residency, same, July 1, 1947-June 30, 1948; pathology fellowship Mayo Clinic, Rochester, Minn., July 1, 1951-June 30, 1954; elected Jan. 5, 1971 by Central Medical Society.

Chapin, Harvey Nathan, Jackson. Born Remus, Mich., July 7, 1935; M.D. University of Michigan Medical School, Ann Arbor, Mich., 1966; Interned Midland Hospital, Midland, Mich., one year; psychiatry residency University of Vermont College of Medicine, Burlington, Vermont, July 1, 1969-Dec. 31, 1969; psychiatry residency University Medical Center, Jackson, Miss., Jan. 1, 1970-July 30, 1970; elected Jan. 5, 1971, by Central Medical Society.

Chase, Vernon Alvin, Baldwyn. Born Michigan City, Ind., March 6, 1939; M.D. University of Mississippi School of Medicine, Jackson, Miss., 1969; interned Baptist Hospital, Jackson, Miss., one year; elected Dec. 8, 1970 by Northeast Miss. Medical Society.

Davis, John Robert, Sr., Corinth. Born Memphis, Tenn., Dec. 27, 1939; M.D. University of Mississippi School of Medicine, Jackson, Miss., 1966; interned same, one year; internal medicine residency, same, July 1, 1967-June 30, 1969; gastroenterology fellowship, same, July 1, 1969-June 30, 1970; elected Dec. 8, 1970 by Northeast Miss. Medical Society.

Dear, Howard Davis, Jr., Jackson. Born Jackson, Miss., Aug. 17, 1939; M.D. University of Mississippi School of Medicine, Jackson, Miss., 1964; Interned Yale-New Haven Hosp., New Haven, Conn., one year; medicine residency, same, July 1, 1965-June 30, 1966; cardiology fellowship, University of Ala. Medical Center, July 1, 1968-June 30, 1970; elected Jan. 5, 1971, by Central Medical Society.

Smith, Perrin Nelson, Cleveland. Born June 30, 1936; M.D. University of Mississippi School fo Medicine, Jackson, Miss., 1964; interned, same, one year; Ob-Gyn residency, same, July 1, 1965-June 30, 1968; elected Oct. 14, 1970 by Delta Medical Society.

POSTGRADUATE CALENDAR

CIRCUIT COURSES

EASTERN CIRCUIT

Columbus—April 27—Session 3; The Downtowner Motor Inn, 6:30 p.m.
Meridian—May 11—Session 3; St. Joseph's Hospital, 6:30 p.m.
Session 3—Goiter in Children, Dr. J. M. Montalvo
Acute Abdominal Conditions in Infants, Dr. Richard Miller

FUTURE CALENDAR

April 27, 1971
CIRCUIT COURSE, COLUMBUS

May 3-6
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

May 11
CIRCUIT COURSE, MERIDIAN

PERSONALS

ORLANDO J. ANDY of Jackson moderated a panel discussion on pain at the American College of Surgeons sectional meeting in New Orleans.

JIM BARNETT of Brookhaven recently took a weekend fishing and scuba diving trip off the coast of British Honduras.

DONALD F. BARRAZA of Natchez announces the removal of his office to Suite A, 142 Jefferson Davis Boulevard. Dr. Barraza limits his practice to dermatology.

JAMES BEASLEY, a native of Calhoun City, has opened practice in Senatobia at 203 South Pannola. Dr. Beasley is a graduate of the University of Mississippi School of Medicine.

W. GRIFFIN BLAND of Gulfport has been elected president of the Gulfport Rotary Club. Dr. Bland is an orthopedic surgeon.

LOREN D. BRELAND, JR., of Crystal Springs attended a service committee meeting and board of directors meeting for the Mississippi Division of the American Cancer Society in Jackson recently. Besides being on the board of directors, Dr. Breland is vice-president for the state.

W. DENMAN BRIDGES of Pascagoula was guest speaker for the March meeting of the Singing River Medical Auxiliary. He spoke on mental health in Jackson County with special emphasis of the new psychiatric section of the extended care unit at Singing River Hospital.

CURTIS W. CAINE of Jackson was guest speaker at the Doctor's Day dinner sponsored by the Lowndes County Medical Auxiliary at the Columbus Country Club. Dr. Caine limits his practice to anesthesiology.

ROBERT E. COGHLAN of Aberdeen was among 15 physicians who took the recent cardiopulmonary resuscitation course at the University Medical Center in Jackson.

EDWARD H. CURRIE has associated with RICHARD G. BURMAN of Gulfport in the practice of obstetrics and gynecology at the Woman's Clinic, 1213 Broad Avenue in Gulfport.

ROBERT N. ERVIN announces the change of office location to Suite 106, Medical Arts Building, 1213 Broad Avenue in Gulfport. Dr. Ervin limits his practice to neurosurgery.

WILLIAM R. FAIN of Jackson presented a paper on "Bullous Disease of Lung" at the American College of Surgeons sectional meeting in New Orleans.

THOMAS H. GANDY of Natchez is currently holding open house on North Pearl Street for his "Myrtle Bank Gallery," a collection of photographic negatives and plates of Natchez and river scenes spanning 100 years.

WILLIAM E. GODFREY of Natchez will be installed as a fellow of the American College of Obstetricians and Gynecologists at the annual meeting in San Francisco on May 3-6.

RUBY B. GRIFFIN, a native of Calhoun County, has joined the Mississippi State Board of Health as a clinician. She will assist Dr. S. H. Davis, health officer and director of the Calhoun-Chickasaw-Webster district.

JAMES H. HENDRIX, JR., of Jackson presided over the morning session on plastic surgery at the American College of Surgeons sectional meeting in New Orleans. Dr. Hendrix also in-

structed a "How-I-Do-It" clinic about lip carcinoma.

M. Beckett Howorth, Jr., of Oxford, former president of the Mississippi division of the American Cancer Society, was guest speaker at the complimentary breakfast to officially kick-off the 1971 Lowndes County Cancer Crusade in Columbus.

W. L. Jaquith, director of the Mississippi State Hospital at Whitfield, was guest speaker at the county-wide meeting of the Gamma Club held in Durant recently. Dr. Jaquith, who was introduced by Dr. Paul B. Brumby of Lexington, MSMA president, spoke on mental health and drugs.

Bart Kendrick, Guy T. Vise, and Frank H. Tucker, Jr., all of Meridian, are serving as this year's chairmen for the Meridian area circuit course series of postgraduate education sponsored by the University Medical Center and MSMA.

John J. Kluck has announced his association with G. A. Bynum of Hattiesburg in the family practice of general medicine at 713 Arledge Street.

William A. Long, Jr., of Jackson was guest speaker at the Brookhaven Kiwanis Club recently. Dr. Long discussed some of his experiences as a physician specializing in adolescent patients.

W. T. Mayer of McComb announces the removal of his offices to 300 Marion Drive, across from the Southwest Mississippi General Hospital.

A. J. Messina, district health officer, was guest speaker at the April meeting of the West Mississippi Medical Society at Vicksburg. Dr. Messina discussed the facilities available at the Warren County Health Department.

Robert J. Peace, a native of Jackson, has assumed new duties as pathologist of King's Daughters Hospital in Brookhaven.

Joseph E. Roe, formerly of Memphis, has associated with the surgical practice of M. Beckett Howorth, Jr., of Oxford in the Oxford Medical Building at 2200 South Lamar Boulevard. Dr. Roe is a graduate of the University of Tennessee.

T. E. Ross, Jr., of Hattiesburg was honored at the Hattiesburg Kiwanis Club's golden anniversary celebration recently. Dr. Ross is the only charter member active continuously in the club since its beginning in 1921.

Frank Schmidt of Ocean Springs was honored on Doctors Appreciation Day at Ocean Springs Hospital upon his retirement from the practice of medicine. At a coffee honoring the medical staff, Dr. Schmidt was presented a gift by the hospital administrator, Mr. Percy Miller.

Jack A. Stacy, Jr., and John M. Blakey, of Tupelo announce the removal of their office from 114 Professional Building to 835 South Gloster Street.

D. J. Van Landingham of Jackson was a participant in FOCUS Week at Blue Mountain College. Dr. Van Landingham spoke on the Bible and medicine.

Thomas Beall Walden, a native of Jackson and formerly of Brookhaven, has assumed his duties as associate pathologist at Memorial Hospital in Gulfport.

Fred Walker of Hattiesburg moderated a panel discussion on hypertension broadcast over WDAM television station recently. Panelists were Hannelore Giles and Duane Burgess of Hattiesburg and Charles A. Hollingshead and Marion E. Cockrell of Laurel. The program was sponsored by the Jones County and Forrest County Heart associations.

Lester D. Webb of Calhoun City was named president-elect of the Mid-South Medical Association at the association's recent annual meeting in Memphis. S. Jay McDuffie of Nettleton was elected vice president.

L. D. Webb of Calhoun City has announced that his office in Calhoun City will be closed after April 30, 1971.

Jackson Ministers and Physicians Meet

Dr. Eugene G. Wood, Jr., of Jackson has initiated a program of ministers-physicians meetings to bring these professionals together to discuss problems of common concern.

Subjects to be included include drugs, abortion, depression, marital difficulties and a broad range of related medical and religious topics.

The initial meeting was held in the Doctor's Library at Hinds General Hospital with Drs. Joseph Scoggins, psychiatrist, and Roland Samson, pathologist, as guest speakers.

The group plans to hold monthly meetings with a variety of guest speakers.

DEATHS

BOREN, FLETCHER CLIFTON, Mantachie. M.D. Memphis Hospital Medical College, Memphis, Tenn., 1911; interned St. Joseph Hospital, Memphis, Tenn., one year; member of Fifty Year Club of MSMA; Emeritus member of MSMA & AMA; presented Golden "T" by University of Tennessee in 1961; died March 2, 1971, age 94.

HAND, ROBERT GRANVILLE, Philadelphia. M.D. Tulane University School of Medicine, New Orleans, La., 1930; interned Charity Hospital, New Orleans, La., July, 1930-Nov., 1930, St. Francis Sanatorium, Monroe, La., Jan., 1933-June, 1933, Charity Hospital, Vicksburg, Miss., June, 1933-Nov., 1933; died March 21, 1971, age 65.

HOLMES, CHARLES EMERSON, Greenville. M.D. Meharry Medical College School of Medicine, Nashville, Tenn., 1932; interned Flint Goodridge Hospital July 1, 1932-Nov., 1, 1932; died July 2, 1970, age 69.

KELLUM, HENRY JACKSON, SR., Tupelo. M.D. Tulane University School of Medicine, New Orleans, La., 1918; interned Matte Hersee Hospital, Meridian, Miss., July 1, 1918-March 1, 1919; residency EENT, EENT hospital, New Orleans, La., Nov., 1931-June 23, 1933; died Feb. 25, 1971, age 78.

KNIGHT, NORRIS C., SR., Jackson. M.D. University of Louisville School of Medicine, Louisville, Ky., 1930; interned Baroness Erlanger Hospital, Chattanooga, Tenn., one year; pediatrics residency Children's Hospital, Chattanooga, Tenn., July 1, 1931-Sept. 15, 1931; public health & preventive medicine residency Johns Hopkins Sept., 1933-July, 1934; received Master's Degree in Public Health, Johns Hopkins University School of Medicine, Baltimore, Md., 1934; secretary of Clarksdale & Six Counties Medical Society 1935-39; Secretary of East Mississippi Medical Society 1939-43; Diplomate of American Board of Preventive Medicine; Emeritus member of MSMA and AMA; died March 31, 1971, age 64.

MAYO, BRYON ABERNATHY, Drew. M.D. University of Tennessee College of Medicine, Memphis, Tenn., 1950; interned Lloyd Noland Hospital, Birmingham, Ala., one year; General Practice residency Long Charity Hospital, Pineville, La., one year; died April 1, 1971, age 46.

MCINTOSH, JOHN S., Jackson. M.D., Tulane University School of Medicine, New Orleans, La., 1904; member of Fifty Year Club of MSMA; Emeritus member of MSMA & AMA; died March 12, 1971, age 95.

SBH Cautions Against Certain Infant Seats

Certain models of collapsible, spring-supported infant seats are potentially hazardous and can cause severe injury to babies, including the amputation of fingers and laceration and abrasion injuries of the hands and face, according to a State Board of Health spokesman.

Dr. W. E. Riecken, Jr., assistant director of General Health Services, said a number of injuries including at least nine finger amputations attributed to the product have been reported to the Food and Drug Administration.

The potentially hazardous items, marketed nationally by several manufacturers, are sold under a variety of brand names, such as "Walker-Jumpers" and "Baby Bouncers."

"While current models of some manufacturers have been redesigned to incorporate safety features," Dr. Riecken explained, "many of the items, presently being sold on the retail market, or in use in the home, have not been modified and may be hazardous."

Injuries have resulted when an infant inserts a finger in a pivotal or spring area of the product or when a unit accidentally tips or folds.

Dr. Riecken advises mothers and others who care for infants to look for the following potentially hazardous areas of walker-jumpers to determine whether the product is safe: holes in hinge areas of reclining models through which a baby could insert a finger; frame pivotal areas, frequently designed in an "X" shape capable of exerting a scissor effort on an infant's finger; unguarded coiled springs which may widen to allow space for finger insertion; absence of a safety ring or locking device in models capable of accidental folding or collapse when occupied; or tendency to tilt or tip when one or two legs hit against a bump, floor crack, rug seam, or the like.

Book Reviews

Medical Pharmacology. By Andres Goth, M.D. 5th Edition. 665 pages with 108 illustrations. St. Louis: The C. V. Mosby Company, 1970. $16.50.

Medical Pharmacology by Andres Goth represents an "essentials" textbook which is generally well accepted by students of medicine. The book is well written and aimed primarily toward two groups with limited time viz., medical students and the practicing physician. We personally feel that its value may be greater to the student group who is learning the actions of drugs for the first time.

The book has the good reputation of frequent revision, and the current edition contains new chapters on subjects of obviously increasing importance such as contemporary drug abuse and drug interactions. We heartily endorse the reference system used to document certain statements or findings, but rather doubt its usefulness to the reader who is seeking essentials and brevity. This book employs well-chosen illustrations which add to its appeal.

I consider the following areas as being insufficiently covered even for an "essentials" book: major tranquillizers, toxicology and agents used for cancer chemo-therapy. The chapter on antiseptics and disinfectants could well be omitted as such information is not only well covered in standard textbooks of medical microbiology, but finds reinforcement with practical application in the laboratory exercises of such courses.

In summary, the book can be recommended as an introductory text covering essentials of medical pharmacology, bearing in mind the reviewer's reservations regarding certain portions. It does not serve the same purpose, nor should it be compared with such books as "Drill" or "Goodman and Gilman."

ARTHUR S. HUME, PH.D.

Hernia Repair Without Disability. By Irving L. Lichtenstein, M.D. 205 pages with 113 illustrations. St. Louis: The C. V. Mosby Company, 1970. $26.50.

These are times when even established, successful procedures are being re-examined. The time and morbidity diminished by fine-honing such commonly performed operations as herniorrhaphy, magnified by hundreds of thousands of patients, have considerable economic and social bearings. This book is an example of what can be accomplished by such reflection and subsequent experience.

The author rapidly and concisely states the problem, its magnitude, and proceeds to focus his critical eye on the commonly employed techniques. The illustrations and printing type are refreshingly large and simple. Each drawing turns on one or only a few teaching points. Repetition of salient facts is insidiously effective.

To this exposition the writer makes his own contribution, to wit: (A) Herniorrhaphy can be effectively performed under local anesthesia; (B) Immediate ambulation from the operating table to the hospital room is accomplished; (C) Discharge from the hospital is achieved within 24 hours of surgery; and (D) Patients return to work as soon as possible, usually within several days, depending on their occupation.

In summary, this volume provides the surgeon with a streamlined method of dealing with hernias. Its surprising effectiveness supports the philosophical truism that reasoned simplicity in treatment is the keystone to successful medicine.

EDWARD M. LOWICKI, M.D.

Singing River Pollution Committee Is Active

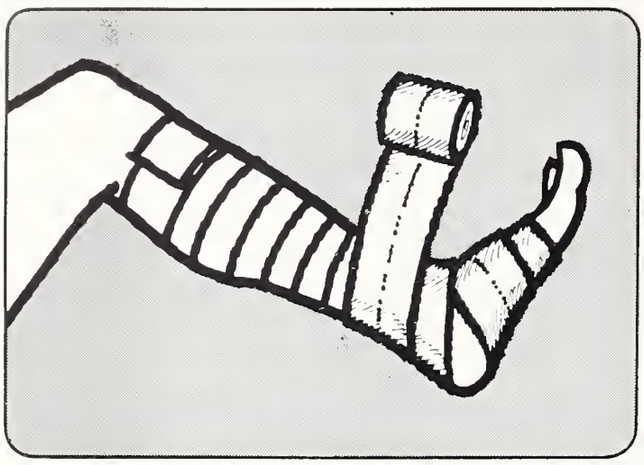
The Water and Pollution Committee of the Singing River Medical Society has joined with the board of directors of the Pas-Point Chamber of Commerce to urge immediate compliance with federal regulations for the Pascagoula water system.

The medical society committee adopted a resolution recommending that the city take immedi-

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ate steps to restore public confidence in the water system by complying with federal standards.

Vincent Blackwell of the Chamber's Governmental Affairs Committee stated the federal government would approve the city water system only if dual chlorinators were installed; a schedule of maintenance adopted; adequate supply and inventory maintained; location and regularity for taking water samples be set; and an overall check of the physical plant.

The medical society adopted a similar resolution. In addition, the committee headed by Dr. Dewey H. Lane, Jr., of Pascagoula, requested that the city establish methods of maintaining the water supply once the defects are corrected.

Meridian Physicians Help With Disaster Drill

Physicians of the Lauderdale County Medical Society took part in a simulated disaster drill held in Meridian recently. The Meridian-Lauderdale County Civil Defense office decided to hold the drill to prepare for possible tornado strikes in the vicinity this spring.

Dr. Thomas D. Little of Meridian was in charge of the triage area to coordinate the dispatching of patients to the hospitals and to give emergency treatment. Medical society members were on hand to process patients.

All private hospitals participated in the drill with their staff members and each provided a triage team of one physician and one registered nurse for the disaster area.

Patient distribution and allocation of ciritical medical items were coordinated between the hospitals over their recently-installed two-way communication system which is also tied in with the Mississippi Hospital Association network.

Charles Dean, Civil Defense director, expressed his "appreciation to all personnel and agencies involved in this effort as it is only by cooperation and working together that we may learn what must be done in a real emergency."

Other groups participating in the drill included Boy Scouts, Girl Scouts, Naval Air Station, Meridian Junior College students, MJC and Matty Hersee nursing students, Red Cross, Air National Guard, funeral homes, Meridian Parks and Recreation Department, and auxiliary police.

University Medical Society Will Be Chartered at 103rd Annual Session

The University Medical Society, created by action of the House of Delegates on Resolution No. 8 at the 102nd annual session, will receive its provisional charter in special House of Delegates ceremonies May 3 at Biloxi.

MSMA president Paul B. Brumby of Lexington and AMA president Walter C. Bornemeier of Chicago will present the charter to Mr. William J. Gibson, Jr., of West Point, first president of the society, and Mr. Don J. Blackwood of Drew, UMC student body president who was instrumental in organizing the society.

Resolution No. 8 established a degree of dues-free membership for medical students regularly enrolled in a medical school approved by AMA which is located in Mississippi. The special component was designated the University Medical Society and members will conduct their own society affairs under the Constitution and By-Laws, including the election of their own officers and delegates.

Association members of the special *ad hoc* committee working with the students are Drs. M. Beckett Howorth, Jr., of Oxford, chairman; Robert E. Blount of Jackson; and W. E. Moak of Richton. Dr. Howorth is an association officer; Dr. Blount is dean and director of the University Medical Center; and Dr. Moak is a member of the Board of Trustees.

The student society is composed of some 95 members of the junior and senior classes at the medical center who applied for membership. The House action encourages first and second year medical students to participate in SAMA, the Student American Medical Association chapter at UMC.

The pre-organizational meeting was held last October with upperclassmen and student body officers together with association officers and the *ad hoc* committee.

In early January membership applications and letters signed by the student body president went to all junior and senior students. Response was prompt with slightly more than half of the eligible students responding. The association's department of administrative services developed a special simplified membership application form for the student society.

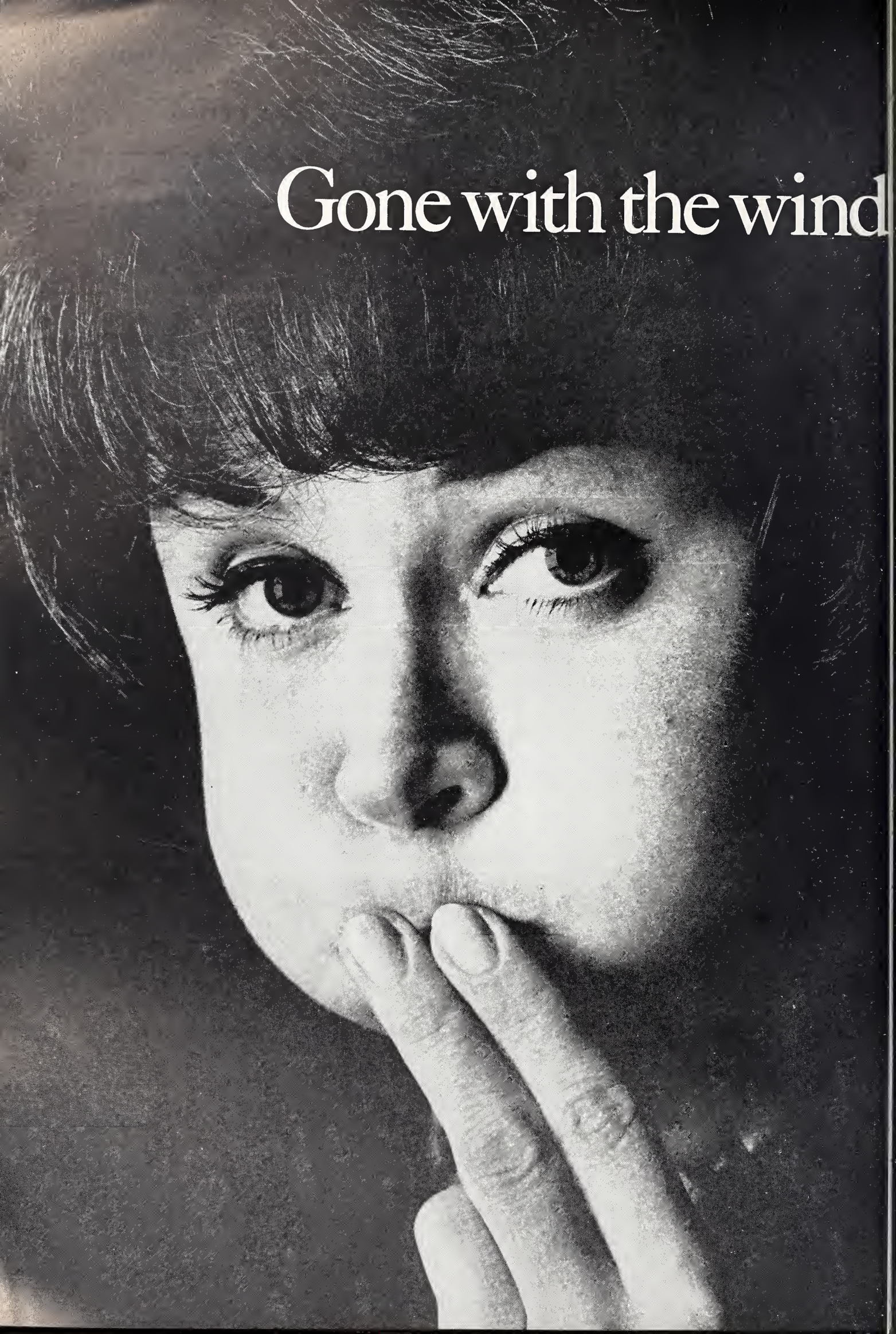
Student body officers drafted the new society's constitution and by-laws, in accordance with the association's, which was approved by the Board of Trustees at its February meeting.

The new society's first organizational meeting was held March 25 to elect necessary officers and delegates to the annual session. In addition to the president who will also be a delegate at this first annual session, Mr. Paul B. Welch of Laurel was elected a delegate.

The society hopes to have monthly programs with guest speakers on medical, legal, and socio-economic topics, according to Mr. Gibson. Service projects, such as volunteer work at the Operation Shoestring Clinic, are also being planned.

Student membership in state medical associations has been urged by AMA. Four state associations have created the new degree: Colorado and Kansas have chartered student societies along the lines of the Mississippi action, while Indiana and Pennsylvania have opened general voting membership to the students.

Association spokesmen said that student membership among state associations is growing, and it is anticipated that more than 25 states will implement a degree of voting membership during 1971.


Gone with the wind

Dr. Davis Is Corinth's Outstanding Citizen

Dr. Frank M. Davis of Corinth was named the Outstanding Citizen of the year at the ninth annual Charity Ball.

Some 450 gave "Dr. Frank" a standing ovation as the award was presented by Mrs. Frank Worsham, III, president of the Corinth Junior Auxiliary, sponsors of the event.



Dr. Davis

A graduate of Vanderbilt University, Dr. Davis completed internship and residency training in medicine and surgery at Cleveland City Hospital, Cleveland, Ohio, and opened his practice in Corinth in 1939.

The general practitioner is active in medical organization and civic activities. He served as vice president of the northern area of the Mississippi State Medical Association in 1960-61, as district 3 member of MPAC board of directors, and is a member of the Council on Legislation.

In 1963 Dr. Davis received the A. H. Robins award for distinguished community service. He has also been president of the Northeast Mississippi Medical Society and received the Certificate of Meritorious Service for leadership in the organizational work of MSMA.

Dr. Davis was recognized in the 1968 edition of Outstanding Civic Leaders of America. He has served 12 years as a member of the Tennessee-Tombigbee Waterway Development Authority and received the award of appreciation.

The physician is a past president of the YMCA board of directors, a Rotarian, 32nd Degree Mason, a Shriner, has served as a member of the Corinth Boys Club board of directors and of the board of review for the Boy Scouts of America. He has been on the board of trustees of Blue Mountain College and is presently on the college advisory committee.

Dr. Davis is a deacon of the First Baptist Church of Corinth, a past president of the Corinth Chamber of Commerce and chairman of the state Civil Defense chapter. He was elected to Who's Who in Mississippi and was presented with a 25 year service pin as medical advisor for the Selective Service.

Other activities of the distinguished physician include medical advisor to the Alcorn County Welfare Association and Heart Fund and county chairman and member of the board of directors of the American Red Cross.

Rush Medical Group Admitted to AAMC

The Board of Trustees of the American Association of Medical Clinics has announced the election of the Rush Medical Group, 1314 19th Avenue, Meridian, to full membership.

The Rush Medical Group, a multi-specialty group, was organized in 1948 by Dr. Leslie V. Rush and Dr. H. Lowry Rush, Sr., when they decided to establish a clinic with various fields of specialization. The group is presently composed of 11 physicians, representing the following specialties: general surgery, gastroenterology, pathology, pediatrics, internal medicine, and cardiology.

The AAMC, located in Alexandria, Va., represents more than 250 group practice clinics throughout the United States and Canada and includes in its membership multi-specialty, single-specialty, and three man group practices.

AAMC membership requirements stress the elevation of the standards of group medical practice, the improvement of graduate medical education and research in group practice, and emphasis is placed on the organizational patterns by which health care professionals attempt to improve the delivery of health care in their own communities.

Medical Malpractice Conference Slated

California Continuing Education of the Bar and the Medical-Legal Society of Southern California will sponsor a National Conference on Medical Malpractice and Doctor-Lawyer Relationships in Los Angeles, July 31 and August 1.

Panels of doctors and lawyers will discuss the prevention and the defense of medical malpractice suits, insurance coverage, and possible alternatives to the present system of malpractice litigation.

Additional sessions will focus on the role of doctors in ordinary personal injury litigation.

Workshop sessions led by both a physician and a lawyer will permit enrollees to participate in discussions of interprofessional problems and attempt to find ways of overcoming traditional doctor-lawyer hostility.

Old Capitol Museum Has Medical Display

As a salute to the physicians of Mississippi, the Old Capitol Museum in Jackson celebrated "Doctor's Day," March 30, 1971, with the opening of a new exhibit of early medical instruments.

The exhibit featured turn-of-the-century medical implements and instruments from several collections on file in the museum including the collections of Dr. A. M. Phillips, Holmes County, and Dr. R. C. Eley, Moss Point, both deposited by the Central Medical Auxiliary, and the collection of Dr. Albert Hand of Shubuta, donated by Mrs. Steve Burwell.

Also featured were items from the newly acquired A. M. Bos collection. Miss Bos, of Vicksburg, a retired medical technician, has gathered, identified and donated to the museum over 100 items of medical interest including the collection of Dr. W. H. Jenkins of Port Gibson.

MAGP Sponsors V.D. Seminar

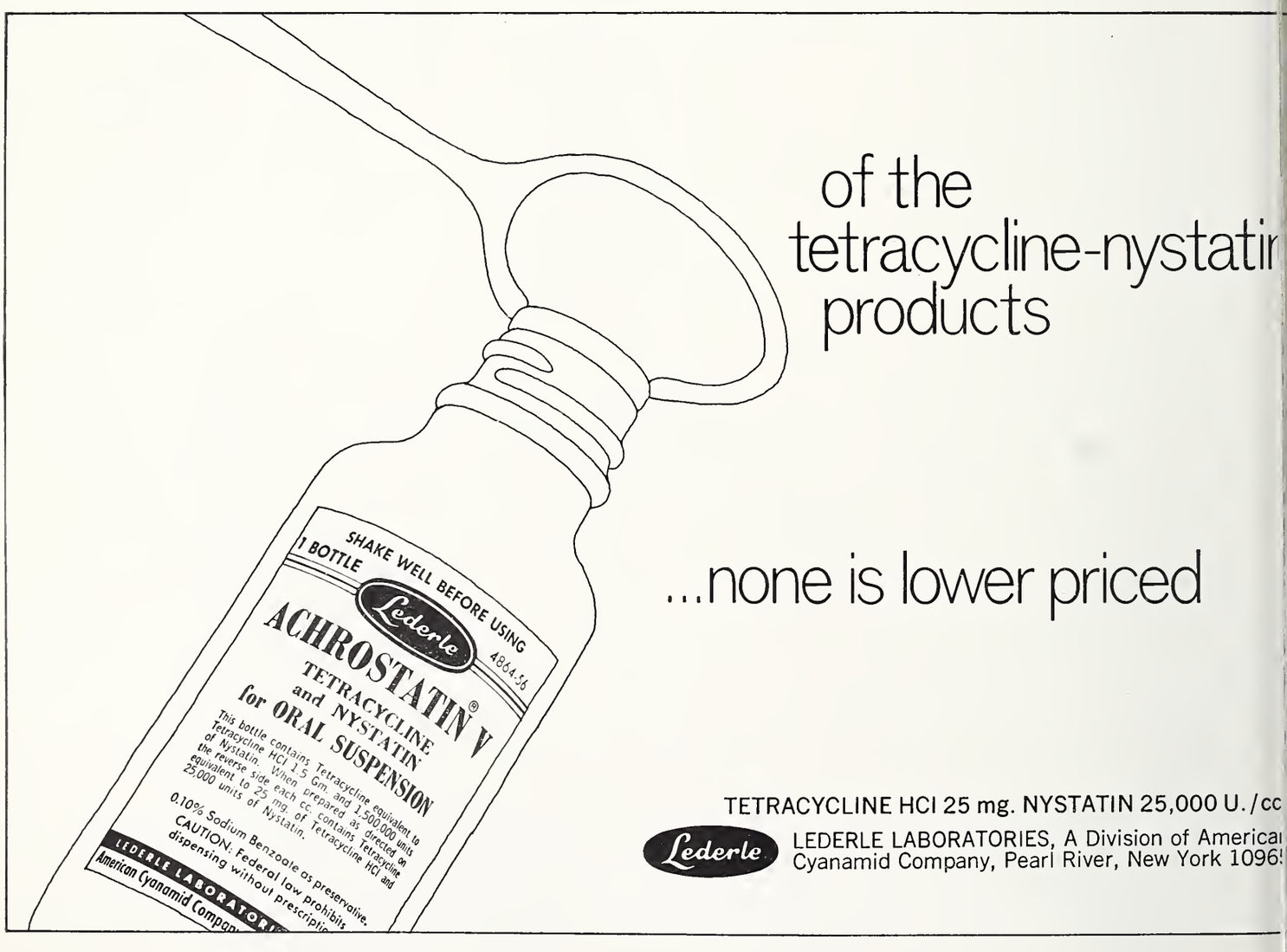
A venereal disease seminar was held at the Pinehurst Hotel in Laurel on April 8. Dr. William H. Parker of Heidelberg, president of the Mississippi Academy of General Practice, was chairman of the seminar program committee.

According to the education commission chairman of the academy, Dr. Charles R. Jenkins of Laurel, the program featured five distinguished authorities who spoke on timely and practical material.

Speakers were Drs. James Lucas and Arnold L. Schroeter of the Venereal Disease Center, USPHS in Atlanta; and Drs. Durward Blakey, Richard H. Andrews and Alfio Rausa of the State Board of Health.

Among the subjects discussed were current diagnosis and therapy of venereal disease, the venereal disease picture in Miss., advances in research, laboratory facilities available and V.D. education in Miss.

The program was acceptable for five hours postgraduate credit in the AAGP postgraduate education program.



Mirex Program Combats Fire Ants in State

An intensive program is underway to eradicate the imported fire ant in Mississippi. Mirex, a chemical which most directly affects the ants, is being administered by the Department of Agriculture fire ant program.

The treatment program was begun in 1970 and some 705,000 acres in Lee, Itawamba and Pontotoc counties were treated aerially.

Mirex bait consists of 85.0 per cent corn cob grits, 14.7 per cent soybean oil and 0.3 per cent mirex. The soybean oil is sprayed on the corn cob grits, then liquified mirex is sprayed on the grits and spread where fire ants have been found. In a standard 1.5 pounds of bait per acre, only 1.7 grams will be mirex.

Mirex is an inert substance with a long life. In a pure state it is a crystalline white solid, odorless, insoluble in water and inflammable. It has been placed on the government list of suspect carcinogens, but officials pointed out that any carcinogenic effects that could occur would result only in much larger concentrations of the chemical than will be found in the fire ant program. The toxicity of mirex is about one half that of DDT.

A complete biometric survey has shown the infested areas to extend from the northeastern corner of the state over to Yazoo County and down to the coast line. Except for very scattered isolated areas, the northwestern part of the state remains free.

Only those areas found to be infested will be treated, such as pasture, meadowlands, crop and orchard lands, highway, railroad and public utility rights-of-way. If requested, program personnel will spot treat towns, residential areas, school and church yards and levies.

The surface water supplies of the state will be avoided. Already treated areas will be resurveyed periodically and any old mounds will be retreated. Officials hope to knock out the isolated mounds along the periphery to check further spread.

A pilot program will be conducted in Scott county this spring. The county will be divided into four quadrants and varying amounts of bait will be applied in each. Officials are attempting to learn the least amount which can be effective in eliminating the ants.

Mr. Woody Owens of Jackson, USDA supervisor of the Plant Protection Division of Miss.-Ala., pointed out that mirex bait mixed with corn cob grits and covered with latex is being tested. The latex covered bait should give longer control without releasing mirex into the environment.

Entomologists will research the effectiveness of the various formulations of mirex bait against the imported fire ant in Scott county. Wildlife and insect samples will be taken from each quadrant to determine if mirex residue is present following the various amounts of treatment and analytical studies will be done.

The fire ant program director, Mr. C. C. Fancher, recently held a meeting of concerned state agencies and other interested organizations to discuss the mirex program. It was pointed out that after the 1970 program, federal Fish and Wildlife officials collected and analyzed wildlife specimens. Some concentration of mirex was found; in a random sample of crayfish, i.e., there were three parts mirex per million.

Mississippi Game and Fish Commission officials have voiced concern about the mirex moving up the food chain and eventually reaching humans. As of yet, no long-term studies have been done to ascertain whether small concentrations of mirex in animals are harmful.

It was first thought that mirex would not biodegrade. However, a study by Dr. James P. Minyard, Jr., state chemist, has found that it does degrade by light and microorganism. Nine months following an application, none, or at the most, only a trace is found.

Environmentalists protesting proposed application of mirex have filed suit in the U.S. District Court in the District of Columbia, praying for injunction against the Mississippi program. Plaintiffs are the Committee for Leaving the Environment of America Natural (CLEAN) of Mississippi and the Environmental Defense Fund of New York.

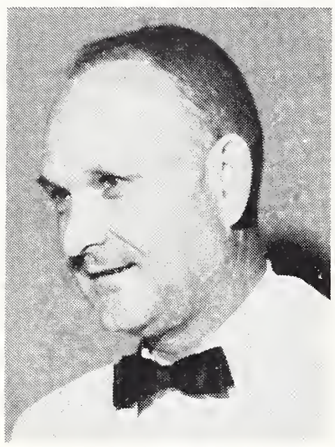
Representatives of state government, principally from the Department of Agriculture and Mississippi State University, have appeared for the defense.

The fire ant has been a medical and veterinary problem in the state for some time. Case studies have shown that fire ant bites can be harmful and even fatal to humans, especially infants and young children. State physicians have reported cases of death, anaphylactic shock and gangrene. Mortality in livestock, especially newborn cattle, etc., has been high in infested areas.

Dr. Ross Receives Methodist Honor

Dr. Thomas G. Ross of Jackson was one of two persons inducted into the United Methodist Hall of Fame in Philanthropy at the 31st annual convention of the National Association of Health and Welfare Ministries of the United Methodist Church held in Denver.

Hall of Fame citations and membership are awarded by the denomination's General Board of Health and Welfare Ministries for outstanding contributions in the health care field.



Dr. Ross

Dr. Ross was honored for 25 years of service to the Methodist Children's Home of Jackson, his work on the Mississippi Annual Conference Board of Health and Welfare Ministries and his efforts in behalf of the new Methodist Rehabilitation Hospital in Jackson.

"This honor comes not only to Dr. Ross but to the entire Jackson area of which he is a part. The kind of spirit recognized in this honor is so characteristic of his everyday life," said Bishop Edward J. Pendergrass of Jackson.

Dr. Ross serves the children's home as president of the board of advisors, an auxiliary to the Board of Directors and Trustees. He is currently the vice-chairman of the Mississippi Conference Board of Health and Welfare Ministries, having served in this capacity for the past three years.

He has been an active member of the Galloway Methodist Church for the past 25 years, serving in 1958 as chairman of the Official Board of the 3,500-member church.

In the summer of 1970, he accompanied a group of youths from his church on a work mission to La Vega, Mexico, where for two weeks he voluntarily conducted a medical clinic, seeing an average of 40 patients a day.

He is also an active supporter of and athletic physician for Millsaps College, from which he graduated in 1936. In 1959 he was recognized as Millsaps Alumnus of the Year, and he is a past president of the Millsaps College Alumni Association.

Dr. Ross is a member of Central Medical Society, MSMA, AMA, American Academy of Family Physicians, Southern Medical Association, and a fellow of the Southeastern Surgical Congress. He received the first annual MSMA-Robins Award for distinguished and outstanding community service during the association's 94th annual session in 1962.

A graduate of the Tulane University School of Medicine, Dr. Ross has served as director and president of the Jackson Fondren Civitan Club; governor of the Mississippi Civitan District, Civitan International; and is active in Y.M.C.A., Chamber of Commerce, Friends of Alcoholics, the Little Red Schoolhouse for the mentally retarded, and the Cerebral Palsy Hospital. He has served as chairman of the professional division of the United Givers Fund.

Dr. Murphy to Give Graduation Address

Dr. Marion Murphy, dean of the University of Maryland School of Nursing, will give the graduation address at the 15th Commencement of the University of Mississippi at the Medical Center on Sunday, June 6. Exercises are set for 4 p.m. at the Jackson City Auditorium.

Dr. Porter L. Fortune, Chancellor of the University of Mississippi, will award degrees to candidates from the School of Medicine, the School of Nursing and the Graduate School. Some 78 expect to receive the doctor of medicine degree this year.

Recipients of the Leathers Medal and the Faculty Award, highest recognition of the medical and nursing schools, will be announced during the ceremony.

A breakfast for graduates and their families on Sunday will open Commencement activities. Prior to the graduation ceremony, Chancellor and Mrs. Fortune will host a 2 p.m. reception in honor of the graduates, their families and friends in the School of Nursing Auditorium at the Medical Center.

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Dr. Ross Retires From Blue Plans Board

A special tribute to Dr. T. E. Ross of Hattiesburg, the last charter member to retire from the board of Mississippi Blue Cross-Blue Shield, was made at the health care plan's annual meeting held at Jackson.

Mississippi Hospital and Medical Service Board Chairman John D. Holland of Jackson presented a resolution at the meeting commending Dr. Ross, who made the motion 24 years ago that created the health care plan in Mississippi.

"More than three decades ago," the resolution states, "Dr. Ross and a few others felt the pressing need, as it then existed, of some organization such as this one through which the great masses of our people could obtain the benefits of substantially prepaid hospital, medical and surgical benefits. . . .



The last charter member to retire from the board of directors of Mississippi Blue Cross-Blue Shield, Dr. T. E. Ross of Hattiesburg (left), is presented an engraved desk set by Mississippi Hospital and Medical Service Board Chairman John D. Holland.

"Today we see it all come true," Mr. Holland said, "We are deeply grateful, and our feeling of debt to those founders is deeply intensified.

"The plan's service to the health needs of our people is eloquent testimony to the vision which Dr. Ross and other Mississippians had a little more than three decades ago," Mr. Holland added.

Mrs. Riddell Is Auxiliary Chairman

Mrs. Mal S. Riddell, Jr., of Winona is general chairman of the 48th annual session of the Woman's Auxiliary to the Mississippi State Medical Association which meets concurrently with the association at Biloxi May 3-4.

Highlights of the ladies' meeting at the Sheraton-Biloxi will include addresses by Dr. Paul B. Brumby of Lexington, MSMA president; Dr. Arthur E. Brown of Columbus, president-elect; Mrs. Virgil Ray Forester of Oklahoma City, AMA Auxiliary representative; and Mrs. Ramsay H. Moore of Dallas, Southern Medical Auxiliary president.



Mrs. Riddell

Mr. Arne E. Larson of Chicago, director of the AMA Department of Medicine and Religion, will be guest speaker for the special luncheon on Tuesday, May 4, in the Top of the Sheraton. Central Medical Society is hostess.

Assisting Mrs. Riddell in planning the annual session are Mrs. J. Gordon Dees of Jackson, luncheon; Mrs. Steve Sekul of Biloxi, registration; and Mrs. John M. McRae, Jr. of Laurel, publicity.

Mrs. Curtis W. Caine of Jackson, 1970-71 president, will preside until Mrs. T. E. Ross, III, of Hattiesburg, president-elect is installed president at the Tuesday morning general session.

A Past Presidents' Breakfast on Wednesday morning will conclude the 48th annual session.

SBH Reports Increased Red Measles Incidence

Red measles is again becoming a problem in Mississippi, according to Dr. Durward Blakey, director of the State Board of Health's Division of Preventable Disease Control, and Paul Turner, supervisor of the State Board of Health's immunization program.

The State Board of Health is trying to control the new upsurge by offering vaccine to susceptible children in affected areas, but 737 cases were reported in the first two months of this year, as compared to only 139 cases for the entire calendar year 1970.

Dr. Blakey and Turner said the problem is "not enough finances, from either the state or the federal government, to continue an all-out, effective effort. If we had that kind of financial support, we could eliminate this disease."

Reviewing the latest surge of red measles, Turner said it first came to light on Jan. 21, when 19 cases were reported from the hospital for Choctaw Indians at Philadelphia. A team was sent to Neshoba county to evaluate the seriousness of the outbreak.

"These team members," said Turner, "contacted all the schools and talked to the doctors in Neshoba county. They found over 70 cases of red measles in the county over a three-week period. They immediately offered vaccine.

"A massive immunization program followed on Feb. 5, in which 984 children in the Indian community and 1,007 other children were reached. This included pre-schoolers, children in day-care centers, and children in kindergarten and in the first eight grades, public and private."

Turner said it was felt that workers should evaluate the entire area. Accordingly, they made a survey in each county bordering Neshoba county and found that Kemper, Newton and Scott counties also had "significant" numbers of red measles cases.

"The most alarming situation," said Turner, "was in Scott county, where over 450 cases had been seen by three physicians since Jan. 1. Scott county schools, especially in the Morton area, were having excessive absenteeism."

Turner said the scope of the survey was then extended into Rankin county, especially the northeast corner of Rankin county, where an increase in the number of red measles cases also had occurred. Rankin, therefore, was designated for a mass immunization program.

A total of 2,363 doses were given in Scott county on Feb. 17, followed by 1,320 doses in Kemper county and 1,602 doses in Newton county and by administration of another 3,335 doses in Rankin county.

"Subsequent evaluation," said Turner, "made it apparent that the epidemics have been curtailed and very few new cases have been reported. But problems linger, due to complications arising from red measles.

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"For example, in the 70 cases of red measles reported in Neshoba county, 20 children were hospitalized with encephalitis (inflammation of the brain) and otitis (inflammation of the ear) and pneumonia, as a result of having the red measles.

"Each of these afflictions, if sufficiently severe, could cause permanent damage to the brain or to the ear or to the lungs. This is a heavy toll to pay for lack of concern for some kind of continuing immunization."

Turner said that the cost of a continuous immunization program would be saved "many-fold," because estimates are that a child who is mentally retarded from red measles can cost the state or its agencies as much as $200,000 over a lifetime.

He said the rushed-up immunization programs for Neshoba, Scott, Kemper, Newton and Rankin counties were made possible by the shipment of vaccine from the reserve stockpile of the Center for Disease Control, Public Health Service, in Atlanta.

Litton Bionetics to Continue Leukemia Research

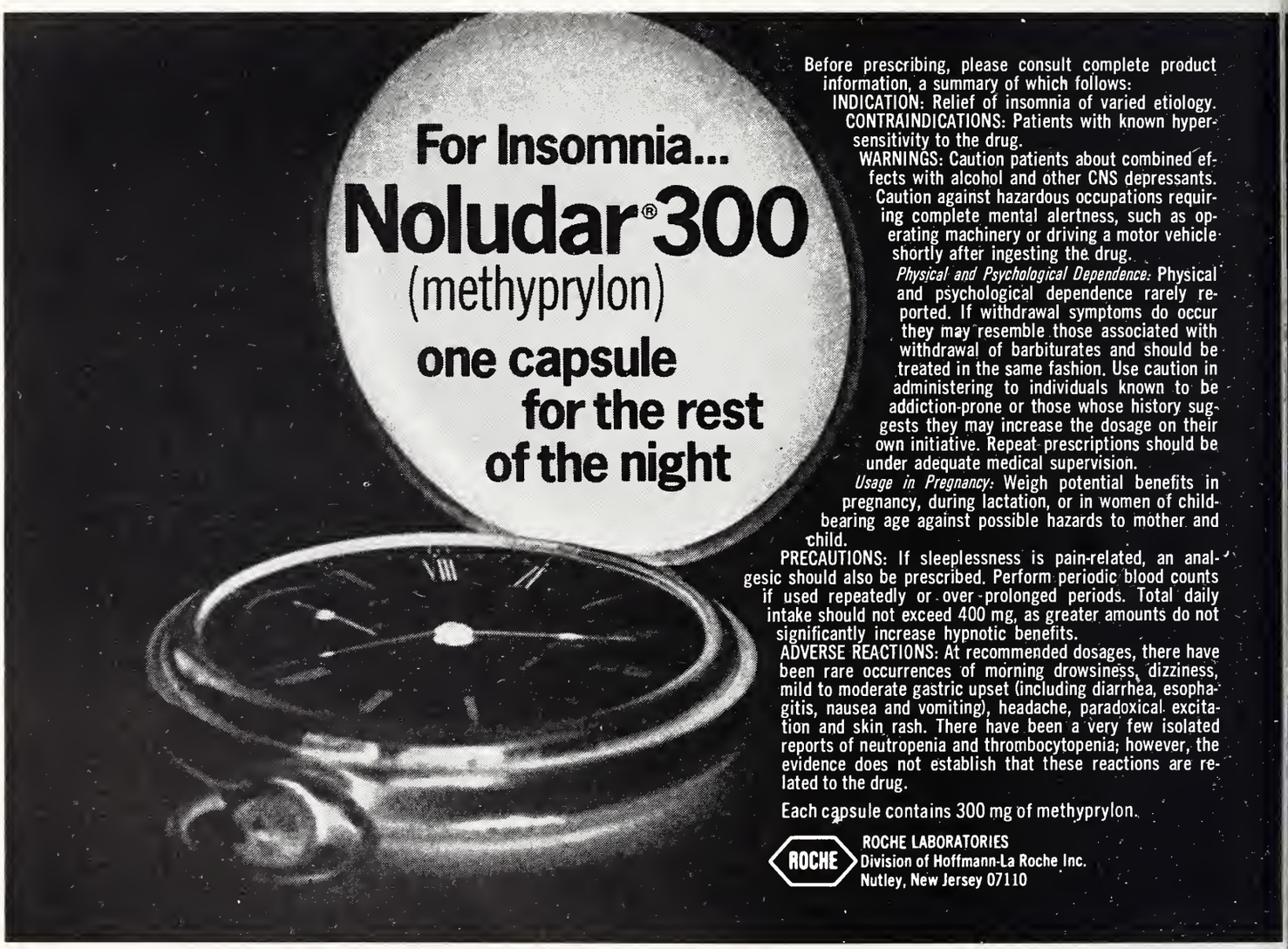
Bionetics Research Laboratories, a division of Litton Industries, has received funding from the NIH National Cancer Institute to continue highly advanced research on the cause(s) of leukemia, it was announced by James Nance, president of the division.

The new funding will further the investigation of leukemia in man. Recently, a Litton/Bionetics research team, under the auspices of the National Cancer Institute, identified an enzyme in human leukemic cells. Significantly, this enzyme was found to be absent in cells from humans not afflicted with leukemia. The enzyme was initially discovered in viruses known to cause cancer in laboratory animals by Drs. Howard M. Temin and Satoshi Mizutani of the University of Wisconsin and Dr. David Baltimore at the Massachusetts Institute of Technology.

It is theorized that the enzyme, known as RNA-dependent DNA polymerase, may be a key element in the development of leukemia. Additionally, in laboratory tests on human cells an antibiotic called N-demethylrifampicin proved successful in inhibiting the possible cancer causing activity of the enzyme. The new research may lead to methods for the early diagnosis of leukemia, when treatment is most effective. Long-range results could provide a means of treating the disease if a way can be found to block the activity of the polymerase in leukemic cells.

The research was conducted by Dr. Robert C. Gallo of the National Cancer Institute's Human Tumor Cell Biology Branch and director of the team, and Drs. Stringner S. Yang and Robert C. Ting of Litton/Bionetics.

At the same time that Drs. Gallo, Yang and Ting were discovering the enzyme in leukemic human cells, St. Louis University virologist Dr. Maurice Green detected the enzyme in animal



ells made cancerous by an RNA virus that could ıo longer be recovered from the cells. Then Dr. Green, working within the Special Virus Cancer Program of the Institute, discovered he could ɔlock the enzyme's activity in the cancer-transormed animal cells by derivatives of Rifampicin, ınd he advised the National Cancer Institute's esearch team of his finding.

In August 1970 Dr. Sol Spiegelman, cooperating in the National Cancer Institute's Special Virus Cancer Program at Columbia University's College of Physicians and Surgeons, had reported inding the enzyme in a total of six cancer-causing RNA viruses.

The supplemental funding will enable the National Cancer Institute/Bionetics team to continue surveying more cells from leukemia patients to further test the validity of the initial findings. The researchers will also attempt to extract the enzyme and separate it from all other cellular materials for more detailed study.

Another aspect of the new research effort will be to determine whether changes in transfer-RNA (the cell chemical that helps to assemble our body protein) may be a factor in the altered growth properties of leukemic and other cancer cells. Several scientists, including Dr. Gallo, have discovered evidence of a chemical difference in some transfer-RNA's from cells of patients with leukemia and normal persons. This difference and other characteristics of normal and leukemic cells must be explored in an effort to find new ways of understanding and perhaps controlling leukemia.

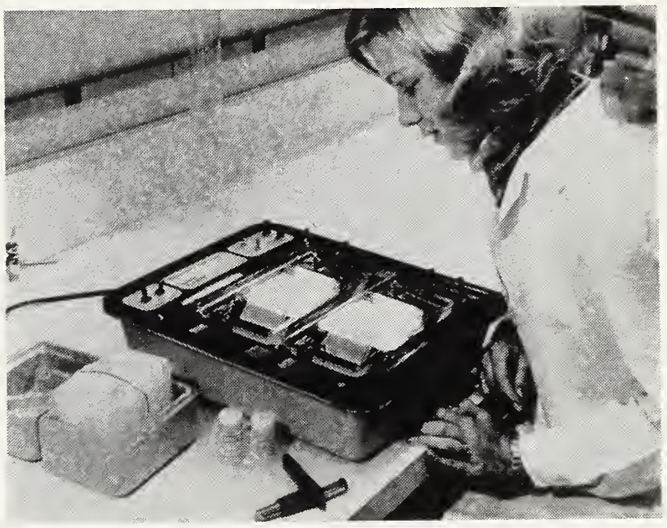
Litton/Bionetics, headquartered in Bethesda, Md., provides a broad range of biomedical services in the areas of life science research, clinical laboratory testing, bioengineering and health care delivery systems.

NIH Approves Hepatitis Detection Test

A product license that will permit the use of a system expected to reduce the incidence of post-transfusion hepatitis by thousands of cases annually has been issued by the National Institutes of Health.

The license, the first of its kind, was granted to the Spectra Biologicals Division of Becton, Dickinson and Company for its hepatitis associated antibody (anti-Australia antigen, human).

A statement issued by NIH said that although testing by this technique does not totally eliminate the threat of serum hepatitis, approximately 25 per cent of donor bloods containing hepatitis associated antigen can now be identified and excluded from medical use.



Laboratory technician at the Spectra Biologicals Division of Becton, Dickinson and Company demonstrates the counterelectrophoresis version of the company's HEPASCREEN hepatitis antigen detection system.

Transfused blood is known to cause more than 30,000 cases of overt hepatitis, resulting in 1,500 to 3,000 deaths every year in the United States. Since there are many sub-clinical cases, the annual incidence has been estimated to be as high as 150,000.

About seven million units of blood are collected in the United States each year. It's anticipated that future legislation may require all donor blood to be screened for hepatitis antigen prior to use.

Under its license, Spectra will be offering two HEPASCREEN™ hepatitis antigen detection systems manufactured at its Oxnard, Calif., facility: agar gel diffusion and counterelectrophoresis. Both are based on a reaction between hepatitis associated antigen in the blood of infected donors and plasma containing antibodies directed against these antigens. The latter system is faster and probably more sensitive and requires an electrophoresis chamber to perform the test.

The agent of hepatitis can be transmitted by the transfusion of whole blood, plasma or plasma components. Transfusion of blood or derivatives containing hepatitis associated antigen results in a high rate of clinical hepatitis correlated with the appearance of the antigen in the serum of the recipients. Hepatitis associated antigen has been found present for as long as three years in the serum of carriers, but it has also been reported that in most patients with the clinical diagnosis of serum hepatitis, the hepatitis associated antigen disappears within several months following the acute phase of the disease.

AHA's Dr. Brown Is Guest Speaker

Dr. Madison B. Brown, deputy director of the American Hospital Association, will be guest speaker for the Northeast Mississippi Medical Society meeting on June 8, 1971.

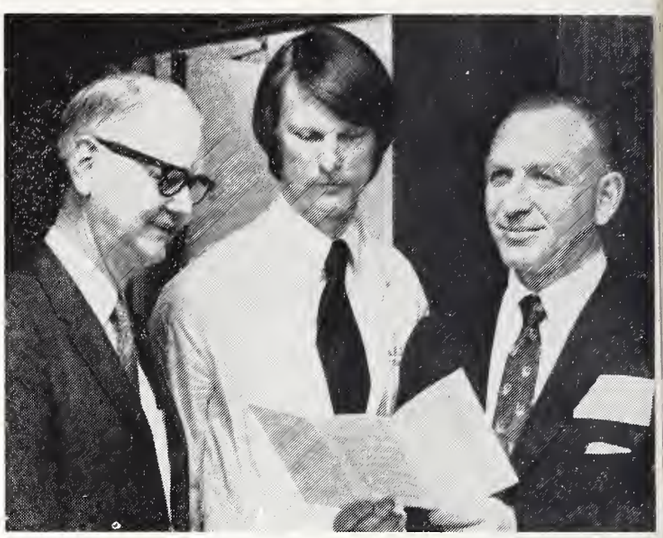
Dr. Brown served as secretary to the Perloff committee which drafted the AHA's Ameriplan for national health insurance in its original form.

Details and ultimate goals of Ameriplan will be Dr. Brown's topic for the evening and there will be a question and answer period.

Dr. Brown is a graduate of the University of Vermont College of Medicine and interned at the Mary Hitchcok Memorial Hospital in Hanover, New Hampshire. He is a fellow of the American College of Hospital Administrators and is currently serving as chairman of the Special Medical Advisory Group of the Veterans Administration.

He is a lecturer in the department of medicine. Northwestern University, and in the course in hospital administration, University of Chicago.

Dr. Stollerman Speaks At Cardiovascular Seminar



Dr. Gene Stollerman, right, University of Tennessee medicine chairman, was one of four guest lecturers at the University Medical Center for the 18th Cardiovascular Seminar, which drew nearly 50 physicians from Mississippi, Louisiana and Arkansas. Here Dr. Stollerman goes over the day's agenda with Dr. J. P. Tatum of Meridian, an MHA past-president, left, and Dr. Bill Causey, UMC medicine resident.

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ACS Announces Surgical Self-Assessment Program

The American College of Surgeons, in cooperation with the National Board of Medical Examiners, has virtually completed its preparations for a program designed to help its Fellows (members) and other qualified Doctors of Medicine evaluate the extent of their basic and clinical knowledge of surgery. Ahead of its schedule for construction of questions, establishment of an administrative mechanism, and for printing the necessary material, the program is expected to be available for interested participants early in the fall of 1971.

The Surgical Education and Self-Assessment Program (SESAP) was initially recommended by the Board of Regents of the College, and subsequently developed by its Committee on Continuing Education under the chairmanship of Dr. James V. Maloney. Jr., department of surgery, UCLA Medical Center, Los Angeles. The National Board of Medical Examiners and 44 nationally recognized leaders in general surgery and the surgical specialties assisted the Committee in working out program content and administrative details.

The purpose of the program is to offer a device by which participants can accurately measure how well they have kept up with surgical progress, define the areas in which they may be deficient, and plan a continuing education program matching their individual needs. Moreover, the program is designed not only to pinpoint for the participant his own position in the arena of today's surgical knowledge, but also to allow him to measure his own progress against the progress of his peers.

"In order to achieve maximum benefit from his educational effort," Dr. Maloney points out, "it is necessary for the physician to identify precisely those areas of medical knowledge in which he has failed to keep up with his peers. Recognition of this defect in postgraduate medical education has led to the concept of the voluntary surgical self-assessment exercise."

The key part of the program consists of a questionnaire containing 750 clinically oriented, objective questions. They are offered in the multiple choice fashion. Covering nine areas, they provide for the practicing surgeon a means for self-evaluating his basic and clinical knowledge in the broad field of surgery.

Schools of Nursing Show Gains

Schools of nursing in the United States reported unusually large increases in the numbers of men and women studying to become registered nurses during the academic year 1969-70, according to the annual survey released by the National League for Nursing, New York.

Admissions to all types of educational programs preparing RNs rose to 75,349 last year, a gain of 17.4 per cent over the previous year's 64,157. During the same period, enrollments increased by 9.1 per cent, to an all-time high of 164,545. Graduations reached 43,639, or 1,443 (3.4 per cent) more than for the preceding 12 months.

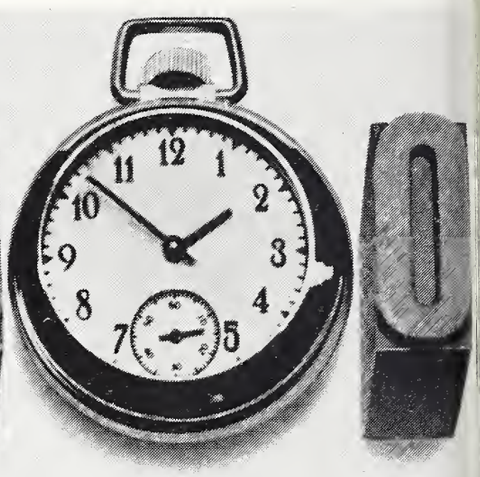
There were 1,355 nursing education programs for registered nurses on October 15, 1970—16 more than the previous fall. This figure reflects a net increase of 54 two-year associate degree nursing programs in community colleges and 16 four-year baccalaureate programs in senior colleges and universities. These gains were offset, however, by the decrease of 54 two-to-three year hospital-based diploma programs. The latter are gradually declining as part of the general movement of nursing education into institutions of higher learning.

NLN general director Margaret E. Walsh expressed gratification at the increased numbers of men and women now preparing for careers as registered nurses. She emphasized, however, that it will be necessary to continue expanding the numbers of nursing students to meet minimum health care requirements. In 1970 approximately 700,000 RNs were employed in the United States, whereas the U.S. Public Health Service put the need at 850,000.

The National League for Nursing's annual survey of nursing school admissions, enrollments, and graduations is undertaken as part of the League's effort to spur community planning for nursing by nursing schools and nursing services.

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MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 20-24, 1971, Atlantic City, Clinical Convention, Nov. 28-Dec. 1, 1971, New Orleans. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

STATE AND LOCAL

Mississippi State Medical Association, 103rd Annual Session, May 3-6, 1971, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Mississippi Academy of General Practice, Annual Assembly, June 24-26, 1971; Biloxi. Miss Louise Lacey, Executive Secretary, P.O. Box 3112, Jackson 39207.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Robert P. Henderson, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Second Wednesday, April and First Wednesday, November, 2:00 p.m., Clarksdale. Glenn L. Wegener, 1967 Hospital Drive, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. James E. Booth, Eupora, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. A. Robert Dill, 1001 Main Street, Columbus, Secretary.

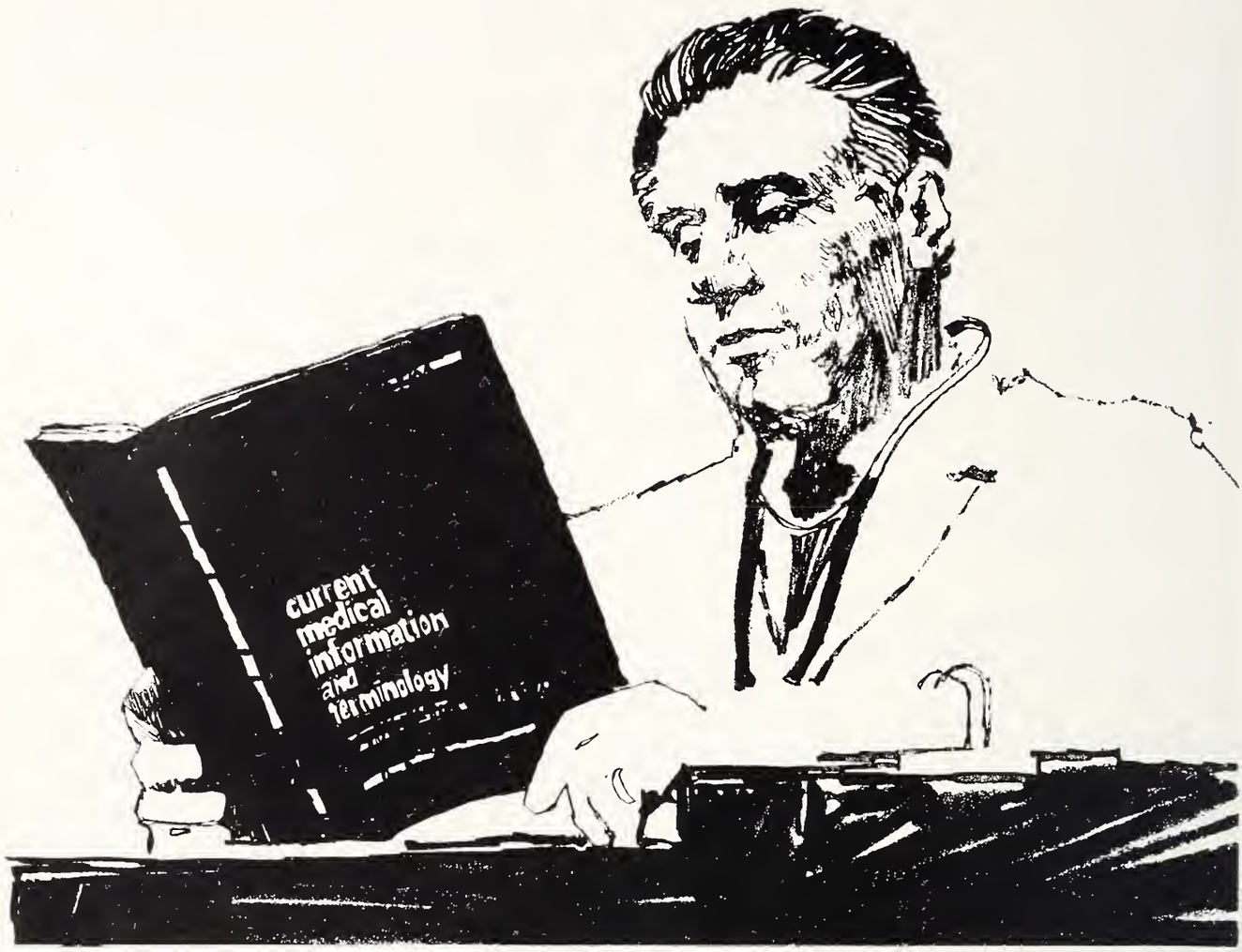
Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Robert Donald, Box 1351, Pascagoula, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie Street, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday, January, April, July, and October, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.

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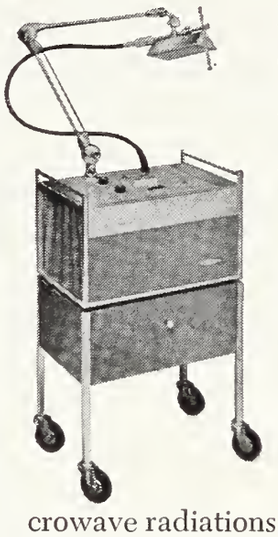
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IN CONCLUSION

American Nursing Home Association has made it official and passed resolution withdrawing support from Medicare. ANHA action says in effect that the government promised something, meaning 100 days care in ECF, which it has refused to deliver. All 7,000 ANHA member homes have been asked to reassess their current participation in Medicare. Resolution says that SSA rules and regulations have literally foreclosed possibility of getting 100 days ECF care.

Phase-in of passive restraints for auto passenger safety has been specified in new standards issued by Department of Transportation. Cars built in 1973 must have passive systems in front seat to prevent injury in 30 mph head-on impact. Cars built in 1975 must hav passive protection systems for all occupants safe in 30 mph crashe lateral impact, and rollover. DOT does not define passive but system has reference to belts, air bags, padding, and nets.

American Public Health Association has endorsed Sen. Ted Kennedy's $77 billion "health security package" as meeting the needs of the nation. After pledging this support, APHA says it will not endors any competing bills, thereby giving shaft to AMA's Medicredit. Support of national compulsory health care is nothing new for public health M.D.'s and officials, since APHA was among the first to endorse Wagner-Murray-Dingell bill in 1944.

Administrative costs of Medicaid are 7 per cent nationwide, accord ing to HEW. Biggest hunk of $6 billion program goes to hospitals which get 37.8 cents of the Medicaid dollar. Other shares are nu sing homes, 30.7 cents; physicians, 11.4 cents; dentists, 5.6 cen drugs, 6.7 cents; other professional services, 0.9 cents; and administration, 7.0 cents. By contrast, hospital share of Medicare dollar is 65.1 cents. Physician fees are frozen in both programs.

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Volume XII
Number 6
June 1971



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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $7.50 per annum; $1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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ications *Male:* Replacement therapy in tes- lar hormone deficiency states. Prevents atro- of the accessory male sex organs following tration for as long as therapy is continued. otence and male climacteric symptoms when to androgen deficiency. Primary eunuchoid- and eunuchism. Delayed puberty when es- ished as not a simple familial trait. Indicated those symptoms of panhypopituitarism re- d to hypogonadism, however, appropriate enal cortical and thyroid hormone replace- ıt therapy remain of primary importance. *ıale:* Palliation of androgen-responsive, ad- ced, inoperable breast cancer ın women be- en 1 and 5 years postmenopausal or women whom castration has shown the tumor to be mone dependent. Prevention of postpartum ast manifestations of pain and engorgement; re is no satisfactory evidence that this drug vents or suppresses lactation per se. In os- porosis androgens may be of adjunctive ue to adequate considerations of diet, cal- m balance, physiotherapy and general health moting measures. *Males and Females:* In the atment of protein depletion states which oc- in geriatric patients, in debilitation states, in onic corticoid therapy, resistant fractures; ptorchidism; creating a positive nitrogen bal- e, tissue repair and other anabolic effects. drogenic steroids may produce a response in astic anemias, myelofibrosis, myelosclerosis, ıogenic myeloid metaplasia and hypoplastic emias due to malignancy or myelotoxic drugs. drogens are not of value in other anemias.

ntraindications Pregnancy (may virilize fe- le fetus), mammary carcinoma in the male, static carcinoma, severe liver disease, severe diorenal disease and severe persistent hy- calcemia.

ecautions Employ with caution in young boys avoid precocious sexual development and mature epiphyseal closure. Androgens tend promote retention of sodium and water, there- e, watch for edema—particularly in the elderly. idence and severity of edema have been nimal and have been associated only with h doses used for palliation of breast cancer. percalcemia may occur, particularly in patients h metastatic breast carcinoma; if this occurs drug should be discontinued. Changes in er function tests, such as increased BSP re- tion and SGOT levels, can occur during ther- y. Jaundice has been rarely reported. If liver ıction tests are altered, discontinue medica- n or reduce dose. Priapism is indicative of cessive dosage and is indication for tempo- y withdrawal of drug. When treating protein pletion states or osteoporosis, an adequate t should be provided and prolonged immobili- ıon avoided whenever possible. When treating lastic or hypoplastic anemias, androgen ther- y should not replace other measure such as nsfusion, correction of iron deficiency, anti- cterial therapy, and the use of corticosteroids.

dverse reactions Nausea, dyspepsia, men- ual irregularities, hepatic dysfunction, pria- sm, edema, precocious sexual development, d premature epiphyseal closure in young tients have been reported. *Male*—Prolonged ministration or excessive dose may cause nibition of testicular function with oligospermia d decreased ejaculation volume. *Female*— rge doses or prolonged administration may oduce masculinization with signs such as hir- tism, deepening of the voice, enlargement of e clitoris, acne, and sometimes, increased ıido.

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Extensive research involving use of a new soft contact lens for correction of visual defects and treatment of eye diseases has won a national award for a University of Florida ophthalmologist.

Dr. Antonio R. Gasset, chief resident and instructor in ophthalmology with the University's College of Medicine, is first recipient of the award, to be given annually by the Rudolph Ellender Medical Foundation in Houma, La. for outstanding achievements in ophthalmology.

Cuban-born Dr. Gasset was cited particularly for his clinical research using a soft hydrophilic contact lens manufactured by the Griffin Company. In cooperation with Dr. Herbert E. Kaufman, professor and chairman of the department of ophthalmology, he has used the new lenses in treating numerous patients with a variety of corneal diseases.

Dr. Gasset reports the lenses have produced especially favorable results in erasing corneal irregularities and in treating bullous keratopathy, the drying syndromes, corneal ulcers and other corneal conditions needing protection.

"Used as bandages, the most remarkable and significant aspects of these lenses is their safety factor," reported Dr. Gasset. "For example, when placed on corneas with large bullae (blisters) and corneal swelling, the lenses do not break the bullae or cause ulceration. They can be worn on corneas with scars and other irregularities without causing ulceration, and are tolerated so well that many patients wear them 24 hours a day for weeks or months without removal," he added.

He noted that another remarkable property of this lens is its ability to take up medication and release it to the eye . . . providing a medicating effect over a long period of time. Studies to evaluate effects of the Griffin lens on the action of medication instilled into the eye were conducted in both animals and humans.

Manufactured from a hydrophilic plastic Bionite, the Griffin lens has a very high water content (about 55 per cent of its bodyweight) making it considerably heavier than the conventional hard lens. The almost instantaneous comfort of the softer lens makes trial lens-testing much easier than with the hard lenses.

Dr. Gasset has been associated with the University of Florida College of Medicine since 1968.



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Indications: For treatment of bacterial otitis externa, bacterial otitis media and otomycosis. In otitis media, this preparation is not effective if the tympanic membrane is intact.

Furacin (nitrofurazone) and Micofur (nifuroxime) are active against a variety of gram-positive and gram-negative organisms. Activity versus Pseudomonas sp. is limited to certain strains. Micofur (nifuroxime) is active against Candida (Monilia) albicans.

Precautions: Sensitization may occur with prolonged use and is more likely to develop in eczematous otitis externa. To minimize such reactions (a) limit application to a week or less, and (b) avoid use of excessive amounts which may run down the face.

This preparation is not indicated for use in treatment of cholesteatoma, where surgical intervention is necessary.

Supplied: Bottle of 15 cc. with dropper.

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NEWSLETTER

June 1971

ear Doctor:

ostgraduate or continuing medical education records will be maintained for Mississippi M.D.'s by the association beginning July 1. he new service assures permanent transcript credit and certification for AMA, MSMA, and AAGP postgraduate programs and requirements. new membership benefit, project was initiated by Council on Medical Education and approved at 103rd Annual Session last month.

> Formal on-campus intensive courses, seminars, and symposia credit will be certified to MSMA by sponsors. Informal or elective credit may be certified by participating physicians in their own behalf. Council on Medical Education will soon publish full information on program.

ew Mexico has nixed chiropractors and eliminated their participation under the state's Medicaid program. Move was effective in May hen New Mexico State Medical Society's medical care foundation ook over Medicaid administration under contract with state government. State society will also conduct peer review in Medicaid under M.D. sponsorship and supervision.

ood and Drug Administration has backed off from arbitrary ruling n combination ingredient drug products. Testifying before House ommittee on Public Health and Environment, FDA Commissioner Charles . Edwards said that ruling was "just a proposal" and that consideration is being given to objections. State medical association was one f objectors, adopting strong resolution against edict in May.

HAMPUS now pays for autopsies as a diagnostic service under program enefits at usual, customary, and reasonable fee charges. Not previously authorized, new benefit also pays cost of autopsy room and mbulance. Only exclusion is when autopsy is ordered by county, tate, or city in which case CHAMPUS will not pay. Autopsies performed in hospital will be paid on inpatient basis.

etail your detail man. So says Dr. J. T. Davis of Corinth, chairan of the association's Board of Trustees. Noting decline in sales f technical (drug) exhibit booths in Mississippi and elsewhere, Dr. avis asks each member to discuss exhibiting at annual session with ach professional service representative who calls. If you visited n exhibit at annual session, be sure to thank PSR for showing.

Sincerely,

Rowland B. Kennedy
Executive Secretary

ACP Urges Treatment of Alcoholism

The American College of Physicians (ACP) has issued a plea for a greater emphasis on the medical treatment of alcoholism.

In an action at its recent 52nd Annual Session in Denver, the ACP's Board of Regents urged "all physicians—and most particularly internists —to become more interested in treatment, education, and research into alcoholism."

The physicians' organization, which represents 17,000 internists and specialists in related fields, urged private practicing physicians to take note of the early signs of addiction to alcohol in their patients, in its earliest stages in order to catch the disease.

"The treatment of advanced alcoholism is unsatisfactory," the ACP statement said, "but this fact does not relieve the physician of responsibility. He treats many chronic illnesses for which no completely satisfactory treatment is available."

"Physicians who are interested and consider the possibility of impending alcoholism in their patients can do much to prevent the disease," the statement continued. "If the alcoholic patient is regarded as a patient in need of help, and if individualized treatment is applied, many can be rendered asymptomatic and others greatly helped."

Bio-Derivatives Bio-Dopa Receives IND Number

Bio-Derivatives Corporation (OTC) has received an IND (Investigative New Drug) number from the U. S. Food and Drug Administration for its Bio-Dopa drug for the treatment of Parkinson's Disease, it was announced by Guy Riccardi, president.

Bio-Derivatives Corporation is the only U. S. company producing the L-dopa drug by a natural process. The company believes that its natural form of Bio-Dopa may have less side effects in patients than the synthetic form of the L-dopa drug.

Bio-Derivatives Corporation also recently initiated a program to license overseas pharmaceutical manufacturers to produce and market Bio-Dopa by the "Riccardi Process" on a royalty basis.

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Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals and is also approved for Medicare patients.

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DATELINE

tor Draft edes on Need

Washington - Selective Service officials have reinstated deferment provisions for draft-liable physicians despite new call-up recently announced. se "serving in critical areas of need" will be exempt from Doctor ft under measure invoked by AMA. Basis of exemption was execue order of April 1970 which went largely unnoticed because there no quota at the time. In addition, new Emergency Health Person- Act of 1970 will probably influence deferments.

. List Is Used Royal Society

New York - American Medical Association has protested to Royal Society for Promotion of Health for sending out solicitation letters for contriions and memberships to American physicians from London. Society legedly made use of American Medical Directory for mailing list purses which is expressly forbidden in AMA copyright. Society is legitte with 32,000 members, among whom are 10,000 outside of British es. AMA has no working agreement with Society, as inferred.

-ERF Chalks Up n Record

Chicago - Loans to medical students, interns, and residents made by AMA-ERF since 1962 now total a whopping $48.5 million. More than 43,600 trainees ve availed themselves of loans, all made possible by voluntarily ven dollars from physicians and Auxiliary members. In Mississippi, -ERF has made 1,016 loans for a total of $1.15 million since 1960, tually all to trainees at UMC. Loans are made from private sources aranteed on 1-to-12 basis by AMA-ERF escrow fund.

Publishes k on Rx Drugs

Washington - New and fascinating book is Brands, Generics, Prices, and Quality - The Prescribing Debate, just published by Pharmaceutical Manuturers Association. The 118-page volume reviews a decade of conoversy over brand-vs.-generic prescribing and the often-followed llacy of generic economy. Interesting section for physicians is at on therapeutics. Single copies are free from PMA, 1155 - 15th ., Washington, D.C. 20005.

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nthrop Labs n Aralen Suit

San Francisco - Winthrop Laboratories prevailed in a liability suit alleging impairment of vision by patient taking Aralen (chloroquine). Califora Supreme Court upheld trial court in finding that patient's contion after taking drug was "an extremely rare result of use of a dication which has distinct value to mankind." Plaintiff said that sion impairment came after taking Aralen for six years for lupus ythematosus.


For the prevention of the gripping pain of angina
Peritrate® SA
Sustained Action (pentaerythritol tetranitrate) 80 mg
A logical choice for the "new" patient with angina pectoris.
See full prescribing information on opposite page.

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Indications: PERITRATE SA Sustained Action (pentaerythritol tetranitrate) 80 mg is indicated for the relief of angina pectoris (pain associated with coronary artery disease). It is not intended to abort the acute anginal episode but is widely regarded as useful in the prophylactic treatment of angina pectoris.
Contraindications: PERITRATE SA Sustained Action (pentaerythritol tetranitrate) 80 mg is contraindicated in patients who have a history of sensitivity to the drug.
Warning: Data supporting the use of PERITRATE (pentaerythritol tetranitrate) during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine, and many other agents.
Precautions: Should be used with caution in patients who have glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.
Adverse Reactions: Side effects reported to date have been predominantly related to rash (which requires discontinuation of medication) and headache and gastrointestinal distress, which are usually mild and transient with continuation of medication. In some cases severe persistent headaches may occur. In addition, the following adverse reactions to nitrates such as pentaerythritol tetranitrate have been reported in the literature: (a) Cutaneous vasodilatation with flushing. (b) Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. (c) An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur, even with the usual therapeutic doses. Alcohol may enhance this effect.
Dosage: PERITRATE SA Sustained Action (pentaerythritol tetranitrate) 80 mg (b.i.d. on an empty stomach), 1 tablet immediately on arising and 1 tablet 12 hours later.
Supplied: PERITRATE SA Sustained Action (pentaerythritol tetranitrate) 80 mg, bottles of 100 and 1000 tablets.
Additional Dosage Forms: PERITRATE (pentaerythritol tetranitrate) 10 mg and 20 mg tablets with or without phenobarbital 15 mg, bottles of 100 and 1000 tablets. PERITRATE with Phenobarbital SA Sustained Action—pentaerythritol tetranitrate 80 mg and phenobarbital 45 mg, bottles of 100 and 1000 tablets.
Warning: Tablets containing phenobarbital may be habit forming. PERITRATE with Nitroglycerin—pentaerythritol tetranitrate 10 mg with nitroglycerin 0.3 mg, bottles of 50 tablets.

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PE-GP-11

Continuing Education Awards Given

More than 20,000 M.D.'s have received the Physician's Recognition Award, established by the American Medical Association in 1969 to honor doctors' participation in continuing medical education.

"A lifetime of learning is lifestyle for physicians," notes Dr. James Z. Appel, member of AMA's Committee on Continuing Medical Education. "Continuing education is essential to the practice of medicine."

The Physician's Recognition Award credits the M.D. for his "lifestyle." It's given for a minimum of 150 credit hours earned over a continuous three-year qualifying period. At least 60 hours are required credits of formal education courses, teaching or publications; the remaining are elective, such as participation in scientific meetings and other self-directed study.

The AMA's Board of Trustees has suggested that participation in continuing education should become one of the requisites for continuing membership in state medical associations. Historically, it has been voluntary and some believe should remain so.

Ninety-five medical institutions and organizations have been formally accredited for continuing medical education by the AMA Council of Medical Education. The current listing of courses includes 2,319 offered in 41 states, the District of Columbia and Puerto Rico. The courses are listed annually in the *Journal of the American Medical Association*. The next listing will be in the August 2, 1971, issue of *JAMA*.

Southern Ob-Gyn Seminar Scheduled

The 17th Annual Southern Obstetric and Gynecologic Seminar will be held at Grove Park Inn, Asheville, N. C. Aug. 1-7, 1971.

Broad areas of obstetrics and gynecology will be discussed by a guest faculty including Drs. Bayard Carter and Roy Parker of Duke University; Dr. Robert Greenblatt of Georgia; Dr. Ed Tyler of California; Dr. Abe Mickal of New Orleans; and Drs. Robert Ross and Charles Hendricks of North Carolina.

Interested parties should contact the secretary, Dr. George T. Schneider, The Ochsner Clinic, 1514 Jefferson Highway, New Orleans, La. 70121.

Medicare Study Results Published

A study of the impact of Medicare shows older people receiving more health services and paying significantly less out-of-pocket, particularly for hospital care, after the program became operational.

"Early Effects of Medicare on the Health Care of the Aged," an article in the April issue of the *Social Security Bulletin,* in reporting the findings of a two-part study carried out jointly by the Social Security Administration and the Columbia University School of Public Health Administration, notes a 25 per cent increase in the number of days of care provided persons 65 and over in short-stay hospitals and an even greater proportionate increase for certain segments of the aged population, such as residents of the South, persons 75 and over, and Negroes.

In each part of the study, a sample of 6,600 Social Security beneficiaries was interviewed by the National Opinion Research Center of the University of Chicago. In interviews for the first part of the study, conducted in April and May 1966, just before the Medicare program became operative, "benchmark" information was gathered on the use of and charges for health services during the previous 12 months. For the after-Medicare part of the study, information was collected in October and November 1967 covering experience in the preceding 12 months.

The author of the article, Regina Lowenstein, assistant professor of administrative medicine at Columbia University, states: "Concrete evidence that Medicare has substantially relieved the burden of the high cost of hospital care for persons aged 65 and over was found in the reduction of out-of-pocket outlays for this purpose. The proportion of total hospital charges paid directly by the patient declined from 38 per cent to 7 per cent, in spite of rising prices, more stays with charges incurred, and a doubling of the average hospital charges per person between the two survey periods."

She also cited these additional effects of Medicare on the health care of the aged: "Before Medicare, charges for 17 per cent of short hospital stays were covered by welfare, voluntary organizations, or other agencies that did not render a bill. Under Medicare, this proportion was reduced to three per cent. The use of long-term medical institutions by the aged did not change under Medicare, but there was a shift from the use of nursing homes to the use of extended care facilities that meet Medicare quality standards and provide a higher level of skilled nursing care."

Brief Summary of Prescribing Information– 9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet b.i.d.
Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

Salutensin®
hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
June 1971, Vol. XII, No. 6

ORIGINAL PAPERS

Evaluation of Lipid Disorders By Lipoprotein Electrophoresis

WILLIAM B. WILSON, M.D.
Jackson, Mississippi

The author describes the technique of electrophoreis which has gained increasing acceptance in the analysis of the serum lipids. The technically simple technique yields fairly definitive clinical information and is essentially similar to that used in the more familiar "serum electrophoresis." Electrophoresis evaluation of the five separate abnormal patterns of serum lipoproteins found by Fredrickson is discussed in detail in this paper.

Analysis of the serum lipids by the technique of electrophoresis has gained increasing acceptance in the past few years, both because of its technical simplicity, and the fairly definitive clinical information which it yields. The technique is essentially similar to that used in the more familiar "serum electrophoresis." In both techniques, a drop of serum is subjected to electrophoresis on a support medium, such as paper or agar gel. Afterwards, the support medium can be stained for protein, thereby bringing out the familiar bands of albumin, and alpha, beta, and gamma globulins; or the support medium can be stained for fat, thereby bringing out the protein-bound lipid components of the serum, or lipoproteins, which also are divided into distinct and identifiable bands. Thus, we have a simple way of characterizing the different serum lipids, or lipoproteins, just as they can be characterized by other methods, such as chemical analysis or ultracentrifugation.

Figure 1 shows an electrophoretic pattern of normal lipoprotein. There are four bands. The dotted line shows the point of application of the serum, which is the origin of the electrophoretic migration. In normal, non-fasting serum, we see a band at this point, representing the chylomicrons. These are absent in normal, fasting serum. At the opposite side of the strip is seen the fastest-moving group of proteins, which are designated the alpha band. These have a high protein content, which gives them a high density. The next fastest band is designated the pre-beta band (which also has been called the alpha-2 band), and it consists of very low density lipoproteins, with low protein content. The band behind this is designated beta, and consists of low-density lipo-

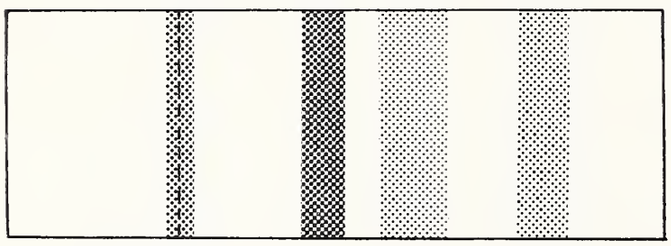
Presented before the Section on Medicine, 102nd Annual Session, Mississippi State Medicine Association, Biloxi, May 13, 1970.
From the Department of Pathology, Mississippi Baptist Hospital.

proteins, with medium protein content. This band is normally darker than the others, and, in the normal state, is discrete, and clearly separated from the pre-beta band by a narrow zone.

Each of these bands is composed of triglyceride, cholesterol, phospholipid, and protein in varying amounts. In other words, while the bands are electrophoretically distinguishable, they all contain varying amounts of the same lipids, as determined by chemical analysis (Table 1). The important things to note here are that the chylomicrons, which are simply particles of nearly pure fat, consist mainly of triglyceride (neutral fat), and the pre-beta band also is about half triglyceride. The main component of the beta band is cholesterol, and the alpha band consists mainly of phospholipid and protein. We also note that the lowest density lipoproteins have the highest content of triglyceride, while the heavier bands contain relatively more cholesterol, phospholipid, or protein.

Given the technical simplicity of a lipoprotein electrophoresis, one wishes to know whether it can be made to yield clinically useful information. Does it permit the diagnosis or prediction of

LIPOPROTEIN BANDS BY ELECTROPHORESIS



(origin) CHYLOMICRONS	BETA	PRE-BETA	ALPHA
(not normally present in fasting serum)	Low density lipo proteins	Very low density lipo-proteins	High density lipo proteins
minimal protein content	medium protein content	low protein content	high protein content

Figure 1

disorders of lipid metabolism? For the answer to this question, clinicians are largely indebted to the studies made at the National Institutes of Health by Fredrickson, Lees, and Levy.[1, 2] Their observations have provided a firm basis for clinical interpretation of lipoprotein electrophoretic patterns, although the significance of variations in the lipoprotein electrophoretic pattern must be further clarified by clinical correlations for many years.

In order to analyze the patterns, one must first have in mind some relevant facts regarding the physiology of fat absorption and transport. Neutral fat (triglycerides), such as animal and vegetable fats, are split in the gut into fatty acids, which are absorbed by the gut mucosa. Here, the

TABLE 1

CHEMICAL COMPOSITION OF LIPOPROTEIN BANDS

	Chylomicrons	*Pre-Beta*	*Beta*	*Alpha*
Triglyceride	87%	52%	10%	4%
Cholesterol	6	18	46	4
Phospholipid	5	20	21	24
Protein	2	10	23	50

fatty acids are reformed into triglycerides, collected into particles, and absorbed via the intestinal lymphatics, or lacteals, into the thoracic duct, which empties them into the jugular vein as particles of neutral fat (chylomicrons). The chylomicrons circulate in the blood stream, and are rapidly absorbed into various body cells, such as adipose tissue, liver, and muscle, where they are split again and formed into fatty acid esters. At this point, they have completed their first transport phase, as neutral fat. When they are released from the body cells, they no longer exist as chylomicrons, but rather, are bound to proteins, as very low density lipoproteins, consisting of about 50 per cent triglycerides, and forming the pre-beta band on electrophoresis.

HIGH CARBOHYDRATE DIET

Another important point is that a high carbohydrate diet results in the formation of adipose tissue, and the subsequent utilization of this adipose tissue by the body results in release into the circulation again of this "secondary" transport form, the very low density lipoproteins, or pre-beta lipoproteins. Thus, either a high carbohydrate or a high fat diet will result in elevation of the pre-beta lipoproteins, which are thus referred to as endogenous lipoproteins, being the main transport form of endogenous fat; whereas the chylomicrons are the main form of transport for exogenous or ingested fat.

On the other hand, the plasma cholesterol level is the result of more complicated metabolic processes, which are poorly understood, and which do not bear such an easily detectable rela-

tionship to diet.[3] Cholesterol should be thought of as primarily a building block, whereas chylomicrons and pre-beta lipoproteins are mainly transport forms. The phospholipids, found mainly in the alpha band, have little known significance in this method of analyzing disorders of lipid metabolism, although they are elevated in obstructive liver disease.

Fredrickson found, after analysis of large numbers of normal and abnormal patients, that he could delineate five separate, but fairly well-characterized abnormal patterns of serum lipoproteins, some of which appeared to be genetically inherited, and he therefore referred to these as "lipoprotein phenotypes." He was able to correlate some of his phenotypes with previously recognized clinical entities, but other phenotypes appeared to be new. He gave each of his phenotypes the non-committal names of hyperlipoproteinemias, Types I, II, III, IV, and V. The lipoprotein patterns are illustrated in Figure 2.

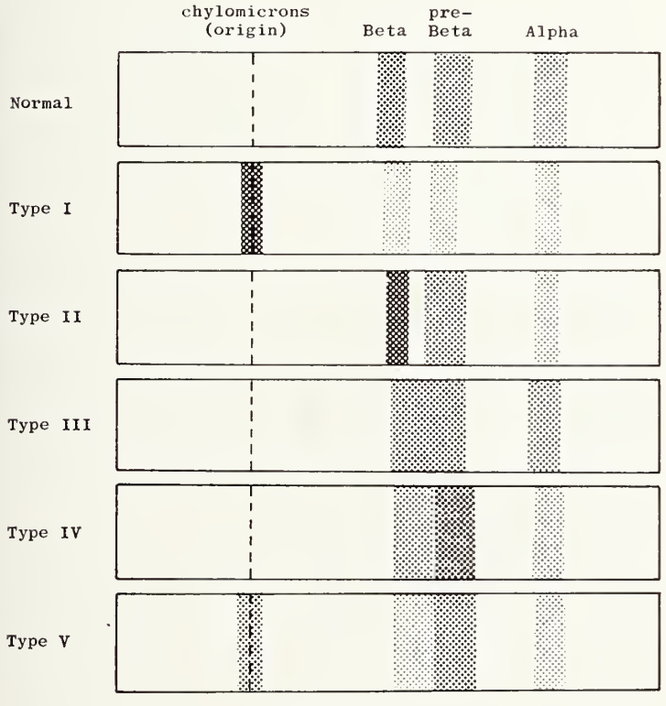


Figure 2

In Table 2 are listed some synonyms for his different types, which have the virtue of illustrating physiologic correlations, or indicating previously recognized entities. Type I hyperlipoproteinemia can well be characterized as exogenous hyperlipemia or fat-induced hyperlipemia, since all the clinical and laboratory abnormalities are produced by ingestion of fat. The third synonym indicates what is thought to be the basic defect, namely, deficiency of lipoprotein lipase, which renders the patient unable to metabolize absorbed, circulating chylomicrons. Type II corresponds to what has been called in the past, familial hypercholesterolemia. It may also be referred to as hyperbeta-lipoproteinemia, since this is the elevated band on the electrophoretic pattern (also the band in which most of the serum cholesterol occurs). Type IV is well described as endogenous hyperlipemia, and perhaps better as carbohydrate-induced hyperlipemia, as this is the most important characteristic of this type.

TABLE 2

SYNONYMS

Type I hyperlipoproteinemia
Exogenous hyperlipemia
Fat-induced hyperlipemia
Lipoprotein lipase deficiency
Type II hyperlipoproteinemia
Familial hypercholesterolemia
Hyper-beta-lipoproteinemia
Type III hyperlipoproteinemia
Type IV hyperlipoproteinemia
Endogenous hyperlipemia
Carbohydrate-induced hyperlipemia
Type V hyperlipoproteinemia

In examining Figure 2, it is noted, in the top strip representing the normal fasting serum, that there is no chylomicron band at the point of origin. There is a fairly intense beta band, which is quite sharp, and distinctly separated from the pre-beta band, which is less dense but nonetheless distinct. This separation is important in analyzing the pattern. The alpha band, which is also well separated from the pre-beta band, is essentially the same in all the abnormal hyperlipoproteinemias illustrated in the succeeding strips.

TYPE I HYPERLIPOPROTEINEMIA

The second strip illustrates Type I hyperlipoproteinemia, with a fairly dense band of chylomicrons, and decreased bands of beta, pre-beta, and alpha lipoproteins. One would expect to find the chylomicron band in normal serum in the post-absorptive state, but it is definitely abnormal in the fasting state, and this is the most important clinical and electrophoretic characteristic of Type I.

Type I is a rare genetic defect, and is clinically apparent in the homozygous state only. The patient is unable to clear the plasma of chylomicrons, and the clinical symptoms are induced by dietary fat. These consist mainly of bouts of abdominal pain, which may be present as "colic" in infancy. The liver and spleen are enlarged because of storage of fat. Distinctive xanthomas, termed "eruptive," are present in the skin. These

are yellow papules, with a reddish base. They represent lipid deposits in the skin with a surrounding, mild inflammatory response. The blood of these patients looks like cream-of-tomato soup. The serum, when separated, is creamy, and fatty particles, or chylomicrons, will rise to the top of it. The diagnosis of Type I hyperlipoproteinemia can be confirmed by the demonstration of a marked drop in plasma lipolytic activity following the injection of heparin. A diet low in fat will promptly cause disappearance of the clinical symptoms, and clearing of the creamy serum, with return of the protein electrophoretic pattern to nearly normal. Type I hyperlipoproteinemia carries no increased risk of accelerated atherosclerosis.

Type II hyperlipoproteinemia is characterized by a discrete, usually marked increase in the beta lipoprotein band on electrophoresis, often with a slight increase in the pre-beta lipoproteins, also. This phenotype is transmitted as an autosomal dominant, and the classic findings are present apparently only in homozygotes, although probably the serum lipid pattern, elevation of serum cholesterol, and a tendency toward premature atherosclerosis are manifested in heterozygotes.

PHYSICAL FINDINGS

Clinically, the patients exhibit bland, tendon xanthomas on the Achilles tendons, and the tendons of the flexor surfaces of the hands and feet; and also bland, tuberous xanthomas, over the knees, elbows, and buttocks. Arcus senilis, and palpebral xanthomas, or xanthelasma, are also present. These physical findings, and also evidence of premature atherosclerosis, may appear in the second or third decade in homozygotes; and possibly later in life, though prematurely, in patients who are thought to be heterozygotes. The fasting serum of uncomplicated Type II patients is perfectly clear, and their glucose tolerance is normal. Obesity and hyperuricemia do not correlate with this type.

In spite of these normal parameters, Type II patients have the greatest danger of premature coronary atherosclerosis of any of Fredrickson's five phenotypes. Thus, several factors which are usually thought to point toward premature atherosclerosis do not correlate with the group having the greatest danger of premature atherosclerosis. On the other hand, Type II patients have the highest levels of serum cholesterol of any group, thereby confirming this widely accepted correlation with atherosclerosis. These considerations thoroughly justify the fairly free clinical use of lipoprotein phenotyping, especially early in life, and in patients with a family history of coronary disease.

DIET REQUIREMENTS

Patients must be on a normal diet for two weeks before phenotyping, since diets heavy in cholesterol and saturated fats may produce, in presumably normal patients, a mild Type II pattern which disappears when the patient returns to a more normal diet. Since the Type II pattern may be secondary to other diseases (to be mentioned later), the diagnosis of primary Type II hyperlipoproteinemia should be confirmed by finding the same lipid pattern in other members of the family in a pattern consistent with an autosomal dominant inheritance; and, if possible, the demonstration of confirmatory physical evidence of characteristic xanthomatosis. Eruptive xanthomas, of the inflammatory type, and milky, fasting serum are not characteristic of Type II, and virtually exclude the diagnosis.

Type III hyperlipoproteinemia is characterized electrophoretically by a "broad beta" band; namely, a fairly dense collection of lipoproteins bridging the beta and pre-beta areas, without vis-

TABLE 3

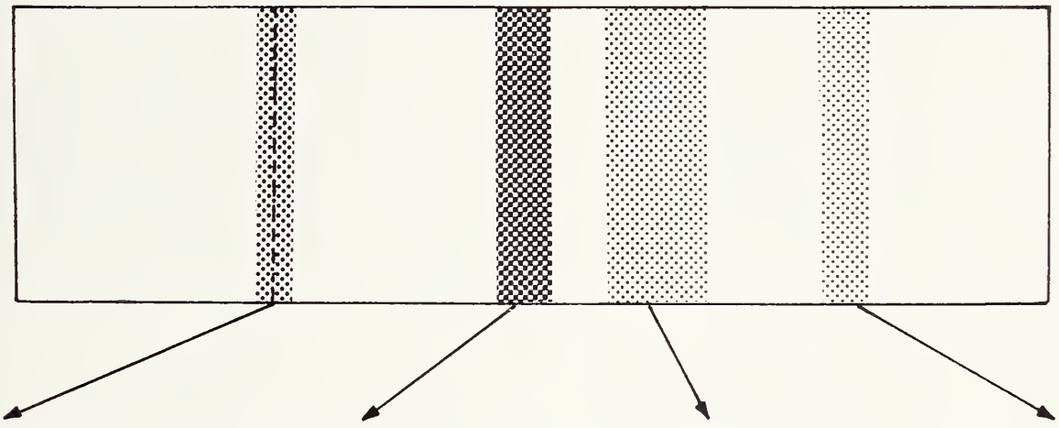
HYPERLIPOPROTEINEMIA
COMPARISON OF ELECTROPHORETIC VS. CHEMICAL CHARACTERISTICS

Type (Fredrickson)	*Predominant Band on Electrophoresis*	*Principal Plasma Lipid Elevation*		
		Triglyceride	*Cholesterol*	*Phospholipid*
I	Chylomicrons	3+		
II	Beta		3+	3+
III	"Broad beta"	2+	2+	2+
IV	Pre-beta	2+	1+	1+
V	Chylomicron, pre-beta	3+	3+	3+

DIFFERENTIAL DIAGNOSIS OF LIPOPROTEIN DISORDERS

Cholesterol and triglyceride determinations

If both perfectly normal, no disorder is present.
If either is abnormal or borderline, do lipoprotein electrophoresis.



CHYLOMICRONS PRESENT:
TYPE I or V
Differentiate by
1. Post-heparin lipolytic activity (I)
2. Clinical features

INCREASED OR BROAD BETA
TYPE II or III or TANGIER D.
Differentiate by
1. Appearance of band
2. Ultracentrifigation
3. Clinical features

If sharp band,
Type II
If broad band
Type III < 1.006
Tangier - absent alpha

If absent or decreased,
Congenital.

INCREASED PRE-BETA
TYPE IV, if isolated abnormality.

Can accompany other types
Differentiate by
1. Pattern
2. Clinical features

ALPHA ABNORMALITIES

Marked increase:
obstructive liver disease

Absence:
1. Parenchymal liver disease
2. TANGIER DISEASE

Only band present:
ABETALIPOPROTEINEMIA

Figure 3

ible separation of the two bands. A well-defined "broad beta" band probably justifies the diagnosis of Type III hyperlipoproteinemia, although to be certain of the diagnosis, the serum should be subjected to ultracentrifugation, upon which it will be found that this entire band is composed of very low density lipoproteins, with a specific gravity of less than 1.006. This is a unique group of lipoproteins of very low density, which are atypical, in that they have beta mobility. These lipoproteins probably serve to define a unique genetic defect, which is apparently expressed only in homozygotes.

Type III patients have clinical features resembling those of Type II in some ways, and Type IV in other ways. They have both tendon and eruptive xanthomas, and milky fasting serum. (The milky fasting serum indicates the presence of triglycerides, in contradistinction to the clear plasma of Type II, in which serum triglycerides are generally normal.) The triglyceride and cholesterol levels of Type III patients are quite variable, and unreliable for diagnosis, which can be made only by lipoprotein electrophoresis, preferably confirmed by ultracentrifugation. The abnormal lipoprotein levels are quite sensitive to changes in diet and total amount of calories. On high fat diets, chylomicrons in small amounts can be demonstrated in the fasting plasma of Type III patients. These patients have a marked ten-

dency toward premature coronary and peripheral atherosclerosis.

Type IV hyperlipoproteinemia is characterized electrophoretically by the isolated elevation of the pre-beta band, consisting of the very low density lipoproteins, or "endogenous" triglycerides. This implies that the endogenous triglycerides are being produced at an excessive rate, or utilized at a subnormal rate. For reasons described under the discussion of physiology, ingestion of carbohydrates aggravates this elevation of endogenous triglycerides, and causes increase in the pre-beta band on electrophoresis in these patients; this type is therefore termed carbohydrate-induced hyperlipoproteinemia.

Typically, these patients are obese, many have hyperuricemia, and 90 per cent have an abnormal glucose tolerance curve. There is usually moderate elevation of both serum cholesterol and triglycerides. Xanthomas are not as characteristic as in the previous types, although patients may show eruptive xanthomas, xanthelasma, and arcus senilis, while tendon and tuberous xanthomas are atypical for these patients.

When this pattern is found in young men, there appears to be an increased incidence of coronary artery disease, although the likelihood of accelerated atherogenesis in this group is not as well established as in Types II and III, in spite of the patients' obesity, hyperuricemia, and abnormal glucose tolerance. Thus, Type IV patients, with elevated cholesterol and uric acid, milky plasma, obesity, and abnormal glucose tolerance, appear to be in less danger of premature coronary atherosclerosis than the Type II patient, who does not manifest most of these "ominous" findings, again justifying the use of lipoprotein phenotyping. The Type IV pattern is the one which is most likely to be secondary to some other disease, to be mentioned later.

Type V hyperlipoproteinemia has electrophoretic and clinical features in common with Types I and IV, namely, chylomicrons and elevated pre-beta lipoproteins on the electrophoretic strip, and milky fasting serum, elevated cholesterol and triglycerides, eruptive xanthomas, obesity, glucose intolerance, and possibly recurrent abdominal pain and hepatosplenomegaly. Some of these patients have been shown to have decreased post-heparin lipolytic activity. They appear to have some increased likelihood of coronary atherosclerosis, although whether Type V is truly a unique phenotype, or a variant of Type IV is not clear.

TABLE 4

LIPID ELEVATIONS IN HYPERLIPOPROTEINEMIAS: CHARACTERIZATION BY DIFFERENT TECHNIQUES

	I	*II*	*III*	*IV*	*V*
Electrophoresis					
Alpha					
Pre-beta		0-1+	3+	4+	2+
Beta		4+	3+		
Chylomicrons	4+				2+
Chemical Analysis					
Triglycerides	4+	0-1+	2-4+	3+	3+
Cholesterol	0-1+	4+	0-4+	1+	1+
Phospholipids		3+	2+	2+	2+
Ultracentrifugation					
Sf 0-12		4+			
Sf 12-100			3+		
Sf 20-400				4+	2+
Sf 100-400	2+				

TABLE 5

GENETICS

	I	*II*	*III*	*IV*	*V*
Autosomal recessive (homozygotes only)	X		X		
Autosomal dominant (homozygotes much more severely affected)		X			
Familial incidence				X	X
Various types of genetic defects likely		X		X	

Figure 3 illustrates a scheme for differential diagnosis of lipoprotein disorders, based upon cholesterol and triglyceride determination, followed by lipoprotein electrophoresis. If both cholesterol and triglyceride are perfectly normal, electrophoresis is unnecessary. It can be seen that chylomicrons are present only in the rarest types, namely, I and V, while the alpha band has no value in the differential diagnosis of Fredrickson's five phenotypes. The differential diagnosis depends mainly upon visual inspection of the beta and pre-beta bands, with due consideration being given to the triglyceride and cholesterol levels, clinical features, ultracentrifugation if needed, and exclusion of other diseases which may produce patterns resembling the primary phenotypes. For the diagnosis of Type IV, the increase in the pre-beta band must be an isolated abnormality, since this band may be elevated in Types II or V, or may be poorly separated from the beta band

TABLE 6

PHYSICAL EVIDENCE OF EXCESS LIPIDS

	I	*II*	*III*	*IV*	*V*
Xanthomas					
* Tendon (Achilles, hands, feet)		X	X		
Tuberous (knees, elbows)		X	X	X	
** Eruptive (furuncle-like)	X		X	X	X
Tubo-eruptive (peanut butter)			X		
Plane (orange palmar streaks))			X		
* Xanthelasma		X	X		
* Arcus senilis (juvenilis)		X	X	±	
**Hepatosplenomegaly (R-E storage)	X			±	±
Serum					
*** Lipemia retinalis	X			X	X
** Turbid serum	X		X	X	X
***Creamy serum with layering	X				±

* Correlates with cholesterol elevation (bland).

** Correlates with triglyceride elevation (inflammatory).

*** Correlates with chylomicrons.

in Type III; thus the evaluation of this band depends upon the presence or absence of other abnormalities as well as the clinical features.

It will also be noted that Figure 3 refers to Tangier disease and abetalipoproteinemia. These are very rare congenital absences of alpha and beta lipoproteins, respectively. Patients with Tangier disease show marked tissue lipid storage, e.g., hepatosplenomegaly, *et al*, due to the lack of the plasma-solubility-stabilizing influence of alpha lipoproteins. Patients with abetalipoproteinemia or hereditary acanthocytosis, show congenital neurological and erythrocytic abnormalities due to lipid defects of the cell membranes. Hypobetalipoproteinemia, with similar, but less severe, clinical manifestations has also been described. These rare diseases will not be mentioned further.

PLASMA LIPID ELEVATIONS

Table 3 shows the elevations of plasma lipids found in each of Fredrickson's five phenotypes. In Type I, characterized by a dense band of chylomicrons, we find that the triglycerides are the main plasma lipid which is elevated, confirming the chemical composition of chylomicrons, as previously mentioned. Likewise, in Type II, with elevation of the beta band on lipoprotein electrophoresis, the serum cholesterol is the most important lipid which is elevated, along with the phospholipids. In Type III, with the "broad-beta" band, composed of the unique group of low-density lipoproteins, we find an elevation of both triglycerides and cholesterol on chemical analysis, as we do also when the pre-beta band is elevated, as in Type IV; and also in Type V. It is evident from this table that determination of triglyceride, cholesterol, and phospholipid levels alone is of virtually no value in the diagnosis of Fredrickson's phenotypes. This is confirmed upon inspection of Table 4, which depicts a rough correlation between the findings by electrophoresis, chemical analysis, and ultracentrifugation.

CORRELATIONS

In examining the column under Type I, we see that there is a correlation between the presence of chylomicrons, triglycerides on chemical analysis, and the lightest group on ultracentrifugation, namely, the S_f100-400 class. Under Type II, we find a correlation between the beta lipoproteins and cholesterol, with the fairly heavy (but nonetheless, "low-density") S_f0-12 class. In Type III, with the "broad-beta" band (depicted in the Table as elevations of pre-beta and beta), we find highly variable levels of triglyceride and cholesterol on chemical analysis, with predominance in the intermediate weight lipoproteins on ultracentrifugation.

In Type IV, with pre-beta elevation, the predominant elevation on chemical analysis is again found to be in the triglycerides, with intermediate weight bands on ultracentrifugation. Approximately the same is true in Type V, with the added presence of chylomicrons, and somewhat lighter bands on ultracentrifugation. Again, however, it is evident that Fredrickson's phenotypes cannot be satisfactorily separated by chemical analysis or ultracentrifugation, because of the

overlap of findings on these types of analysis.

Thus, one asks, "Is each of Fredrickson's five phenotypes a truly unique population of patients, and is his division of patients into these five types justified?" The answer to this is not really known. Lipoprotein phenotyping appears to clarify the significance of obesity, milky plasma, abnormal glucose tolerance, and hyperuricemia, by correlating these findings with fairly distinctive lipoprotein patterns. Type I hyperlipoproteinemia was recognized as a clinically distinctive, fat-induced abnormality of lipid metabolism well before Fredrickson's work, which carried no increased risk of atherogenesis in spite of the startlingly lactescent plasma. Homozygous Type II has long been recognized as a distinct, though rare disease, under the name of familial hypercholesterolemia, although the significance of presumably heterozygous Type II hyperlipoproteinemia has not been established in spite of Fredrickson's work; he himself thinks that Types II and IV may represent a common phenotypic expression of a variety of genotypes, because of the highly variable clinical manifestations found in different family lines showing these types of lipoprotein patterns, especially Type IV.

GENETIC RELATIONSHIPS

Although the homozygosity of Types I and III is well established, as well as that of the severely affected Type II patients, the genetic relationships, if any, of the presumably heterozygous Type II patients, and those of Types IV and V, are not well established. However, by lipoprotein phenotyping of patients and their relatives, we can get some idea of whether a particular lipid pattern is probably inherited, or possibly secondary to some other disease, which helps significantly in the rational management of these patients. The presumed genetics of Fredrickson's phenotypes are summarized in Table 5.

Table 6 summarizes and compares the physical evidence of excess lipids in the different phenotypes, and shows some approximate correlations between serum findings and physical findings. In general, xanthomas related to high plasma cholesterol cause little tissue reaction, while those related to high plasma triglycerides cause a mild inflammatory reaction, as does any neutral fat deposited in tissues (e.g., acne, ruptured sebaceous cyst). Hepatosplenomegaly reflects simply reticuloendothelial storage of the excessive plasma fat, as confirmed by the finding of foam cells in the bone marrow in these patients. Type III hyperlipoproteinemia shows a distinctive variety of xanthoma, termed tubo-eruptive, which resembles a bit of peanut butter beneath the skin, and also peculiar, pathognomonic bright orange streaks in the palms and soles.

INCIDENCE OF MANIFESTATIONS

Table 7 depicts a rough estimate of the incidence (but not severity) of various clinical manifestations of each of the five phenotypes. This Table should not be taken at face value, however, since there is considerable difference of opinion in the literature regarding these points, probably reflecting diagnostic standards of varying rigidity, and statistical studies of varying reliability. This Table reflects the views of Fredrickson, primarily.

The same remarks apply to Table 8, which depicts the influence of various factors on the serum lipid pattern. It should be noted that Type II is relatively insensitive to diet. Stress, and cigarette smoking have not been clearly related to any given lipid pattern, although these factors are thought possibly to produce a tendency toward the Type IV pattern. It is uncertain whether a distinctive

TABLE 7

ESTIMATED INCIDENCE OF VARIOUS CLINICAL MANIFESTATIONS
(This does not refer to severity)

	I	*II*	*III*	*IV*	*V*
Accelerated coronary atherosclerosis		4+	3+	2+	?
Accelerated peripheral atherosclerosis		2+	3+	2+	?
Glucose intolerance			3+	4+	4+
Obesity				4+	2+
Hyperuricemia				2+	2+
Childhood manifestation (homozygotes)	4+	4+			
Manifestations in early adulthood		2+	3+	2+	3+
Bouts of abdominal pain	4+			2+	3+
Evidence of pancreatitis	2+			1+	

serum lipid pattern alone, without overt clinical manifestations or other diseases, can serve to establish the diagnosis of one of Fredrickson's phenotypes. It also will be noted that the Type IV lipid pattern is the one most likely to be secondary to other diseases.

These diseases are listed in Table 9. Uncontrolled diabetes appears to be capable of producing any of the abnormal phenotypic patterns except Type II, while maturity-onset diabetes is associated only with the Type IV pattern. When considering the physiology of lipid metabolism, it is easy to see that some of these diseases probably result in induction of the Type IV pattern (predominantly the pre-beta or endogenous triglycerides), because of excessive mobilization of adipose tissue (e.g., diabetes, glycogen storage

TABLE 8

INFLUENCE OF VARIOUS FACTORS ON LIPID PATTERN

	I	*II*	*III*	*IV*	*V*
Diet	4+	2+	4+	4+	3+
Alcohol				2+	2+
Stress (?cigarettes)				?	
Serum lipid pattern without overt clinical manifestations or other diseases					
?diet-induced		2+		4+	
?heterozygotes		4+			
Likelihood that lipid pattern is secondary to other diseases	1+	2+	1+	4+	2+

disease) whereas others produce the Type IV pattern because of some degree of carbohydrate induction (e.g., excessive alcohol ingestion); while the abnormal lipid pattern in still others probably represents the presence of abnormal proteins or abnormal protein binding (e.g., nephrotic syndrome, dysglobulinemias, liver disease).

The proposed treatment of the various phenotypes is summarized in Table 10. Dietary manipulation is of fundamental importance in all types. Type I requires simply restriction of all fats, whereas weight control is probably of benefit in all types except I, and possible II. The dietary management of Types II and III is essentially the Keys Diet, low in cholesterol and saturated fats, and high in unsaturated fats. Type IV, the carbohydrate-induced type, is treated primarily by carbohydrate restriction and liberal dietary fat, while Type V requires restriction of both carbohydrates and fat, with the calories being made up in protein.

TABLE 9

CAUSES OF SECONDARY HYPERLIPOPROTEINEMIAS

	I	*II*	*III*	*IV*	*V*
Uncontrolled diabetes	X		X	X	X
Maturity onset diabetes				X	
Pancreatitis	X			X	X
Alcoholism	X			X	X
Hypothyroidism		X		X	
Nephrotic syndrome		X		X	
Dysglobulinemia		X	X	X	
Glycogen storage disease				X	
Pregnancy				X	
Parenchymal liver disease			X		
Obstructive liver disease		X			
Excess dietary cholesterol and saturated fat		X			

In conjunction with dietary management, drug treatment with clofibrate (Atromid-S) is satisfactory in Types III, IV, and V, but less satisfactory in Type II, as evidenced by the listing of multiple drugs for this type. Binding of cholesterol in the gut with beta-sitosterol or cholestyramine (permitted for experimental use only, in treating hyperlipemias) may well be the most satisfactory drug treatment for Type II. Clofibrate, cholestyramine, and d-thyroxine each lower the serum cholesterol by 10 to 20 per cent, but since athero-

TABLE 10

TREATMENT

	I	*II*	*III*	*IV*	*V*
Weight control		?	X	X	X
Diet low in all fats	X				X
Low cholesterol		X	X		
Low saturated fats		X	X		
High unsaturated fats		X	X		
Low carbohydrates				X	X
High fat				X	
High protein					X
Alcohol restriction				X	X
Clofibrate (Atromid-S)		X	X	X	X
Cholestyramine (expt.)		X			
D-thyroxine		X			
Oral hypoglycemics (±)			X	X	X

genesis appears to be exponentially, rather than arithmetically, related to the serum cholesterol level, the lowering of serum cholesterol by only this small percentage may result in a much larger decrease in deposition of atherosclerotic plaques.

TABLE 11

RESULTS OF TREATMENT

	I	*II*	*III*	*IV*	*V*
Plasma lipids approach normal	4+	1+	3+	2+	2+
Fat storage & pain regress	4+				2+
Xanthomas regress	4+	1+	3+	2+	2+
Atherosclerosis prevented		?	?	?	?

Type II—the more marked the abnormality, the better the response to treatment.

As can be seen in Table 11, the results of treatment vary considerably with the phenotype, being most satisfactory in Types I and III, which are the rarest but probably best understood; and least satisfactory in Types II and IV, which are the commonest.

As a general rule, the more marked the abnormality, the better the response to treatment. Whether return of the plasma lipid toward normal represents a worthwhile result, of course, is debatable. Xanthomas can be seen to regress slowly under treatment, and it is not unreasonable also to assume that the progress of atherosclerosis is decelerated, or possibly reversed, again probably more effectively in the more severely affected individuals. However, we are still left with only question marks about the matter of prime significance, as to whether treatment of these patients retards atherogenesis. ★★★

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19TH HOLE REPERTOIRE

Two golfers caught up with a slow playing woman's twosome. Observed one of the golfers: "I had better hide. . . . That's my wife playing golf with my mistress. . . ." Whispered the other, also ducking behind some shrubbery, "What a coincidence! Mine, too!"

—from the *Hawaii Medical Journal*

Chromosome Analysis in Newborns: Clinical Considerations

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The newborn with abnormalities presents a challenge to the clinician. Prompt diagnosis is essential to determine patient care and to adequately counsel parents. Knowing that as many as eight per cent of infants with multiple abnormality syndromes and that one per cent or more of all infants born may have chromosome abnormalities, it is obvious that chromosome analysis is an important diagnostic aid. It should be employed when: (1) a trisomy or deletion syndrome is suspected, (2) a syndrome of multiple abnormalities is present which fits no known syndrome, and (3) true genetic sex of an infant is in question. The more frequently seen syndromes of chromosome abnormalities in newborns have been described to alert the physician who first sees the infant in the nursery.

CLINICIANS, ESPECIALLY PEDIATRICIANS, are frequently called upon to make a diagnosis on an infant with one or more physical abnormalities. It has been estimated that approximately 14 per cent of all newborns exhibit a single recognizable anomaly. As many as 0.5 per cent of newborns will have three or more minor anomalies and of these 90 per cent will have major defects as well.[1] The term "funny looking kid" has been applied to a number of syndromes in which there are unusual facies with or without skeletal or other systemic anomalies. Many of these syndromes have a genetic basis. This may either involve duplication or loss of chromosome material which can usually be detected by a chromosome analysis, or an aberration in gene or genes structure which is not detected by chromosome analysis.

It is important to see other members of the family, especially the parents, to try to determine if a pattern of inheritance can be established. If so, the problem is probably due to a gene abnormality. An example is craniofacial dysostosis or Crouzon's disease which is inherited as a simple autosomal dominant. If no pattern of inheritance can be established, then the multiple abnormality syndromes not known to be associated with a chromosome abnormality should be considered. Chromosome analysis should follow if the diagnosis is still in question. Some of the more common non-chromosomal "funny looking kid" syndromes are listed in Table 1.[2]

It has been estimated that as many as one per cent of all newborns have some type of chromosomal abnormality. It is likely that the figure of one per cent is an underestimate.[3] Of the multiple abnormality syndromes as many as *eight per cent* may be due to a chromosome abnormality. Therefore, it is obvious that the problem is not a rare one and that a practitioner must be able to recognize the more frequent syndromes, especially those that are life-threatening, at cribside.[1]

The presence of an additional chromosome in a karyotype making three of a particular chromosome rather than the usual pair is called trisomy. There are three well established trisomy syn-

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dromes. The most frequent of these is *Down's Syndrome* or mongolism, and this occurs approximately once in 500 births. It is important to know the mother's age because in the age range below 30 years the initial risk is near 1/1000 whereas, after the age of 45 years, the risk is nearer 1/40. Early diagnosis is important because of the implication it holds for the patient and his parents as to his development, his care, and the possibility of having other affected infants in future pregnancies.

Accuracy of diagnosis of Down's Syndrome in the nursery depends to a great degree on the experience of the physician because the characteristic physical signs given in Table 2[4] are not always present or clearly defined. Hall gave the following 10 signs as most important in order of frequency of occurrence in the newly born mongoloid: (1) flattened features, (2) absence of Moro reflex, (3) hypotonia, (4) oblique palpebral fissures, (5) excessive skin on back of neck, (6) hyperflexibility, (7) dysplastic pelvis, (8) dysplastic ears, (9) short fifth finger with single flexion crease, and (10) transverse palmar crease. None of the infants he examined had less than four of these signs.[5] Of course many of these signs can occur as isolated findings in normal newborns. Infants with Down's also tend to weigh less at birth causing the incidence of prematurity by weight to be near 30 per cent.

The most frequently associated complications are congenital heart disease (present in approximately 30 per cent), leukemia (20 times the expected incidence) and small bowel obstruction. Newly born infants with Down's who have no severe associated anomaly usually do well in the nursery. They sleep a great deal, may feed slowly, and make few demands because of their reduced responses to stimuli.[6]

The syndrome is due to an extra chromosome 21 causing a trisomy state. In a majority of cases this is due to a nondysjunction in meiosis presumably of the egg, and produces a free number 21 chromosome. It is not known why this happens

TABLE I

"FUNNY LOOKING KID" SYNDROMES

Syndrome	*Heredity*	*Facial Characteristics*	*Associated Abnormalities*
Hallerman-Streif (dyscephaly with congenital cataract and hypotrichosis)	Multifactorial (described in homomonozygotic twins)	Face is small, birdlike; widely patent fontanelles; congenital cataract; hypoplastic mandible; hypotrichosis; dental anomalies, blue sclerae	Dwarfism; syndactyly (normal intelligence)
Rubinstein-Taybi (broad toes and broad thumbs syndrome)	Only sporadic cases reported thus far, but probably multifactorial	Antimongoloid slant of eyes; beaked nose; small mandible	Retardation; frequent infections; short, broad thumbs and toes; cardiac abnormalities
Orodigitofacial dysostosis (OFD syndrome)	Described only in females; probably a sex-linked dominant; may be lethal in males	Cleft tongue; pseudo cleft in upper lip; hyperplastic frenulum; cleft palate (1/100 cases of cleft palate are OFD syndrome)	Syndactyly, other anomalies of hands, mental retardation is associated in a number of cases
Cornelia de Lange Syndrome	Multifactorial; reported in several families	Heavy eyebrows meeting in midline; general hirsutism; antimongoloid eyes; low-set ears; arched palate	Severe retardation; micromelia; syndactyly; skeletal defects; congenital heart disease
Bird-headed dwarf of Seckel (primordial dwarfism)	Multifactorial; reported in siblings	Microcephaly; beaklike nose and preponderance of central portion of face; antimongoloid slant of eyes; hypoplastic mandible	Dwarfism; mental retardation; hypotonicity skeletal anomalies; anomalies of genitalia

Syndrome	*Heredity*	*Facial Characteristics*	*Associated Abnormalities*
Robin's Syndrome (Pierre Robin)	Multifactorial; apparently involves maldevelopment of first arch area	Micrognathia, cleft palate and glossoptosis; "Andy Gump" appearance	Mental retardation in 20%; hydrocephalus; congenital heart disease
Crouzon's (craniofacial dysostosis)	Autosomal-dominant	Craniostenosis with microcephaly, exophthalmos; beaked nose; mandibular prognathism	Syndactyly; optic atrophy; simian lines; mental retardation
Apert's (acrocephalosyndactyly)	Autosomal-dominant (may have varying penetrance)	Craniostenosis with oxycephaly; exophthalmos	Syndactyly varying in degree to true osseous fusion; mental retardation
Idiopathic infantile hypercalcemia (associated with supravalvular aortic stenosis)	Multifactorial; vitamin D sensitivity	"Elfin" face; small skull (craniostenosis); epicanthic folds; strabismus; a retrousse nose; underdeveloped mandible; wide mouth	Hypotonia; hypercalcemia; dwarfism; mental and psychomotor retardation; heart disease
Hemihypertrophy (Silver's syndrome)	Multifactorial; reported in several generations	Involves all the facial structures, including teeth	Associated with increased incidence of Wilms' tumor; hemihypertrophy of one side of body, including internal organs
Ellis-van Creveld (Chondroectodermal dysplasia)	Autosomal-recessive (25% of patients have affected siblings)	Sparse scalp and eyebrow hair; fusion of upper lid to gingival margin; natal teeth; abnormal dentition	Polydactyly; acromelic dwarfism (distalward shortening of extremities); congenital heart defects; mental retardation
Progeria (Hutchinson-Gilford syndrome)	No hereditary pattern described	Small face; appearance of newly hatched bird; alopecia; ears small; nose beaked; small mandible	Dwarfism; death due to old age and coronary disease in teens; osteoporosis

though aging of the egg, radiation, viruses, drugs and other agents have been proposed as possible causes. The expected recurrence rate for this type of Down's is approximately two per cent.

In rare cases the extra number 21 chromosome is found to be attached or translocated to one of the other autosomes. This translocation type is more often found in infants of younger mothers. Both parents of any infant found with translocation type of 21-trisomy should have chromosome analysis to determine if either is a carrier of the translocation in a balanced state. This is important for counseling as the odds of producing another affected child if a parent carries a translocation can be as high as 33.3 per cent or even 100 per cent depending on which autosome bears the translocated 21.[4]

An even rarer form of Down's is the *mosaic type* (approximately 1/3000 in general population) in which some of the patient's cells contain a normal number of chromosomes while others contain the additional 21. These infants may appear as typical mongols or present with only a few signs. Parents of these infants also should have chromosome analysis to see if either has a cell line containing the extra chromosome in order to counsel them about an increased incidence in future offspring.[6]

EDWARD'S SYNDROME

The *17-18 or Edward's syndrome* occurs in about 3/10,000 newborns. Usual features include failure to thrive, small mandible, low-set and deformed ears, hypotonicity and clenched hands with the index finger flexed over the third finger. Other abnormalities may be present especially of the heart (greater than 50 per cent), the kidneys (10-50 per cent) and the gastrointestinal tract

(10-50 per cent).[1] The hand and finger signs plus the short mandible are especially important clues. (See Figures 1, 2.) The findings are listed in Table 3.[4]

These infants have a limited capacity for survival and as such constitute a "genetic emergency." About 30 per cent die during the first month and 50 per cent by the second month. Only 10 per cent survive to a year of age and they are severely retarded. Obviously it is important to have confirmation of the diagnosis as soon as possible in order to prepare and inform the parents. Many physicians also recommend limiting heroic and expensive medical means for prolongation of the affected infant's life. As the production of an affected infant is thought to be a sporadic occurrence the risk of recurrence is only slightly greater than that for the general population. Only rarely have translocation types been found.

The *13-15* or *Patau's syndrome* is also a "genetic emergency" and these infants in many ways resemble the 18-trisomy. The occurrence rate is 1/5,000 newborns.[1] A list of findings is given in Table 4.[4] The most important clues to diagnosis are cleft lip and/or cleft palate, scalp defects, polydactyly, microcephaly, microphthalmia, "rocker-bottom-feet" and heart defects. (See Figures 3, 4.)



Figure 1. Note clenched fist with index finger overlapping third finger in 17-18 Trisomy.

These infants fail to thrive, have severe mental deficiency and often seizures. Forty-four per cent die in the first month and 69 per cent are dead by six months. Only 18 per cent live to one year. They tolerate corrective surgery poorly and because of the high mortality it is best to withhold extensive treatment until later in life. Again the recurrence rate is negligible unless a translocation type is found.[1]

DELETION SYNDROMES

The *Cri-du-Chat* ("cat-cry") syndrome is a rare syndrome so named because these infants have a characteristic weak mewing cry like that of a kitten. They are generally of low birth weight and gain slowly. Microcephaly, epicanthic folds, downward slanting of the palpebral fissures, hypertelorism, and Simian creases are frequent findings. They are all mentally deficient.

The chromosome finding in a patient with Cri-du-Chat syndrome is a loss of part of the short arms of one of the number 5 chromosomes. Most cases are sporadic with little risk of recurrence.

TABLE II

CLINICAL FINDINGS IN DOWN'S SYNDROME (MONGOLISM)

Mental Retardation	Transverse Palmer Crease
Round Head	Ulnar Loops on All Fingers
Short Nose	High Axial Triradius
Epicanthic Folds	Short Crooked Fifth Finger
Conjunctivitis	Single Fifth Finger Crease
Brushfield Spots in Iris	Short Broad Hands
Upward Slope of Eyes Laterally	Arch Tibial Pattern of Foot
Enlarged Protruding Tongue	Short Neck
Fissured Tongue	Hyperflexibility
Irregular Teeth	Narrow High Palate
I-V Septal Defect	
Wide Interspace, First and Second Toes	

A syndrome with *loss of short arm material of chromosome 4* has also been described. The infants lack the mewing cry but do have low birth weight, poor growth, epicanthic folds and Simian creases. They also tend to have seizures, a down-turned "fish" mouth, strabismus and frequently cleft lip and/or cleft palate. Profound mental deficiency has been a constant feature. All reported cases have been sporadic.

Another rare syndrome is the *long arm 18 deletion syndrome* which is characterized by microcephaly, growth failure, mental retardation "fish"-shaped mouth, long tapering hands and fingers, abnormal toes and especially a narrow or even atretic external auditory canal with conductive deafness. These children should be identified early because some are not as severely retarded as others and efforts should be made to correct the hearing defect.[1]

Sex chromosome abnormalities involve much less characteristic physical findings and the diagnosis may not be recognized at birth. Ambiguous genitalia may be due to endocrine disorders in the infant, to maternal hormones or to sex chromosome abnormalities. This problem was discussed in the article by Dr. Montalvo who recommends basic endocrine studies and a buccal smear for sex chromatin to determine the number of X chromosomes as an initial work-up.[7] Adrenal hyperplasia causing masculinization in a female infant would be detected by increased 17-ketosteroid levels and a positive buccal smear. Chromosome analysis may be necessary to establish diagnosis of a mosaic state as in true hermaphrodites who have both XX (female) and XY (male) cell lines and in whom the sex chromatin count

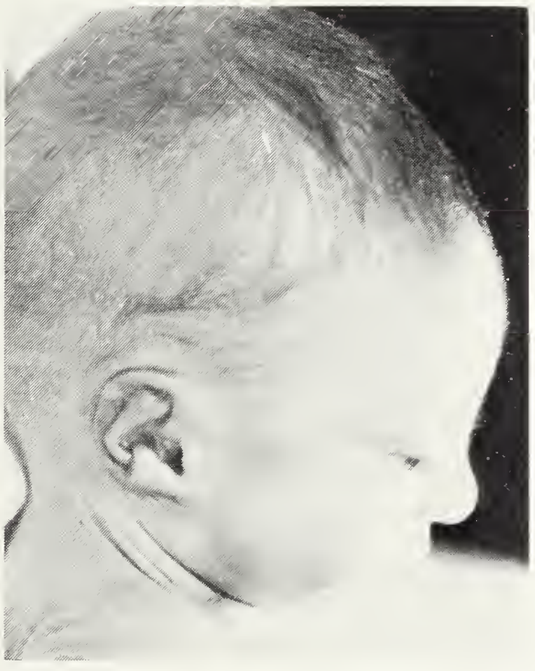


Figure 2. Note short mandible and low-set malformed ears in 17-18 Trisomy.

would be positive but below normal in number. These infants have both ovarian and testicular tissue and the genitalia may be ambiguous or normal.

The *testicular feminization syndrome* in which the genitalia are female but the genetic sex is XY (male) is rarely recognized in newborns. Occasionally the infant may have hernias or the testes may be palpated in the inguinal area or the labia. Any female appearing infant with these findings deserves further work-up with sex chromatin study and chromosome analysis. However, any doubt as to an infant's true genetic sex should be resolved by a chromosome study.[7]

TABLE III

CLINICAL FINDINGS IN 16-18 TRISOMY SYNDROME

Mental Retardation	I-V Septal Defect
Failure to Thrive	Patent Ductus Arteriosus
Ears Low-set and Malformed	Prominent Occiput
Small Mandible	Hernia
Finger Flexion, Index and Third	Foot Deformities
Dorsiflexion of Big Toes	Renal Anomalies
Hypertonicity	

Also: Meckel's diverticulum, heterotopic pancreatic tissue, short sternum, small pelvis, eventration of diaphragm, loose skin folds, syndactyly of second and third toes, interatrial septal defect, corneal opacity, pyloric tumor, malrotation of colon, harelip and cleft palate, ptosis of one eyelid, high-arched palate, short neck, high number of arches in dermal patterns.

Turner's Syndrome or gonadal dysgenesis is found in approximately 1/3,000 newborn females. In most cases it is due to an absent X chromosome giving a total chromosome count per cell of 45 rather than the normal 46. The buccal smear is negative. In other cases the syndrome may be due to a mosaic state as XO/XX or to the loss of only a portion of the X chromosome. In these the buccal smear may be positive but in a lower than normal percentage. The clinical findings are the same with only minor variations.

Young girls with Turner's Syndrome may show short stature, webbed neck, low hair line, increased carrying angles of the arms, "shield" chest, failure to develop secondary sexual characteristics,

TABLE IV

CLINICAL FINDINGS IN 13-15 TRISOMY SYNDROME

Mental Retardation	Eye Defects
Deafness	Congenital Heart Defects
Seizures	Hyperconvex Fingernails
Cleft Palate	Hemangiomata
Cleft Lip	Polydactyly

Also: Horizontal palmer creases, low-set ears, flexion of fingers and hands, lacunar skull, retroflexibility of thumbs, rocker-bottom feet, hypotonia, spina bifida, micrognathia.

and lack of menses. The female infant, however, may present no physical signs though a short

neck, excessive skin folds at the nape of the neck, edema of the dorsum of the hands and feet, "shield" chest and wide-spaced nipples have been found with suggestive frequency. The genitalia are normal female. Less common findings include heart disease (especially coarctation of the aorta), short fourth metacarpals, webbing of the digits and hypoplastic nails. Any of the above signs should alert the clinician to the possibility of Turner's syndrome and a buccal smear should be obtained as a first step in diagnosis.[2]

KLINEFELTER'S SYNDROME

Klinefelter's Syndrome is probably the most common sex chromosome abnormality occurring in approximately 1/400 live male births. These male infants have an extra X chromosome giving a chromosome count per cell of 47 and a positive buccal smear for sex chromatin. As adults they may present with sterility, small testes, eunuchoid stature, gynecomastia, sparse body hair and occasionally mental retardation. Diagnosis of this syndrome prior to puberty is difficult, however, as these infants usually present no abnormality at birth other than occasionally hypospadias which has been found more often in Klinefelter's Syndrome than in the general popu-



Figure 3. Note cleft lip and palate and polydactyly in 13-15 Trisomy.

lation. As hypospadias may also be associated with true hermaphroditism, any infant with hypospadias warrants at minimum a sex chromatin study.[8]



Figure 4. Rocker-bottom feet in 13-15 Trisomy.

Other abnormalities of sex chromosomes such as the *triple-X female* and the *XYY male* present no characteristic syndrome in newborns. ★★★

2500 North State Street (39216)

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Radiologic Seminar CVIII: Gastric Duplication—Illustrative Case With Massive Hemorrhage

CARL R. HALE, M.D.
Hattiesburg, Mississippi

GASTRIC DUPLICATION is a rare lesion resulting from a congenital error in development of the stomach most frequently encountered in the pediatric and young adult age groups. It usually consists of a tubular or hollow structure very intimately attached to normal alimentary tract most often along the mesenteric border. It has one or two well developed muscle coats often sharing one with the muscularis coat of the normal structure to which it is attached. Usually it is lined with alimentary tract other than that to which it is attached. Almost always the lesion contains fluid, the nature of which depends on the type of mucosal lining cell. Of all the duplications of the gastrointestinal tract, those of the stomach seem to be the most rare.[1, 2, 3]

As early as 1907 embryologic explanations for the formation of gastric duplication and congenital diverticula were put forth by Lewis and Thyng. However these explanations have largely been replaced by the thinking of observers like Bremer who feel that duplications of the stomach result from adhesions between the walls of the dorso-ventral slit portion of the two-month embryonic stomach. The adhesions serve as a framework for the subsequent growth of endothelium and effectively isolate this portion of the gastric cavity from the rest of it. Subsequently the isolated cavity and normal cavity of the stomach develop independently, and the former becomes the duplication.[4, 5]

Clinically, symptoms most often include emesis, epigastric pain and particularly in infants, intolerance to feeding. Less often there is melena and hematemesis, sometimes massive. Occasionally there is a tender palpable upper abdominal mass. On gastrointestinal series there may be no findings or there may be an extrinsic impression on the barium filled stomach. In all reported cases there was leukocytosis, but hemoglobin was reduced only if there was melena or hematemesis. All the other routine laboratory findings were normal unless the location of the lesion or sudden complication of the lesion produced additional effects which would be reflected in laboratory values such as pancreatitis.

The treatment is surgical. The preferred treatment is removal of the duplication with the least amount of attached gastrointestinal tract possible; however, often the lesion is so large or so involved with some organ structure that this is not technically feasible; then the procedure of choice depends upon the situation in that particular case. The first reported excision of a gastric duplication was by Wendell in 1911.[6]

Since then many procedures have been utilized including partial excision of the duplication with anastomosis of the remainder of the lesion to the cardia of the stomach, creating a congenital di-

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Forrest General Hospital, Hattiesburg, Miss.

verticulum, resection of a portion of the stomach and duplication and occasionally when necessary, destruction of the mucosa of the duplication and creating a communication with the stomach, or in an occasional case, marsupialization.[7, 8]

The present illustrative case is that of an eighteen-year old male referred for a gastrointestinal series with a history of sudden onset of epigastric distress with increasing severity for a few days followed by vomiting of a small amount of fresh appearing blood. Two days later hematemesis in small amounts again occurred and one tarry stool was identified.

Figures 1 and 2 show the first gastrointestinal series at which time no significant abnormality could be identified after an extensive search for a bleeding lesion.

Two days after the gastrointestinal series he vomited 900 cc's of blood most of which appeared fresh and bright but some of which was dark. Upon admission the hemoglobin was 9.8 grams and the WBC was 12,100. Figures 3 and 4 show a dramatic change in the appearance of the follow-up gastrointestinal series which was done six days after the first examination. The changes included a large lesser curvature pressure defect on the cardia and antrum with spill of barium from the stomach into a large sac-like cavity. The pattern was not that of a typical lesser peritoneal sac, therefore barium was felt to lie in a walled off pouch or possibly in an evacuated tumor mass.

There was epigastric tenderness but no palpable mass. At laparotomy a large gastric duplication was identified. It was intimately attached to the posterior wall of the stomach and shared one muscle coat with it. The lesion extended into the retro-peritoneal space extensively, up to the spleen, and involved the pancreas. The latter portion of the duplication contained a large ulceration penetrating into the pancreas. Only a small communication was noted with the stomach and it was felt that stasis was the problem producing the ulceration. For this reason a gastric duplication jejunostomy was performed for adequate drainage, and at four months follow-up the patient has done well clinically. ★★★

Forrest General Hospital (39401)

ACKNOWLEDGEMENTS

Appreciation is expressed to Dr. Warren Dale of Lumberton, Miss. and to Dr. Richard H. Clark of Hattiesburg for the use of this case.

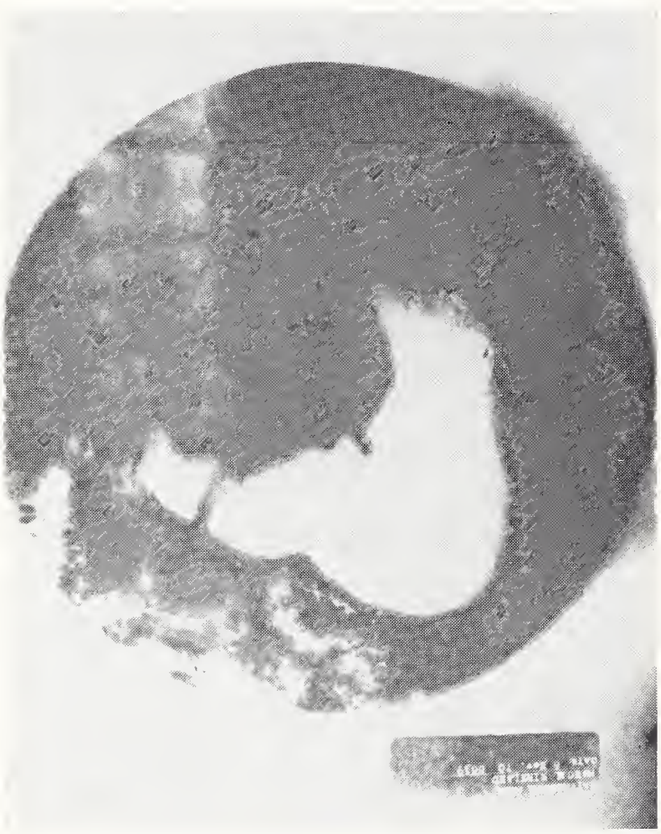


Figure 1

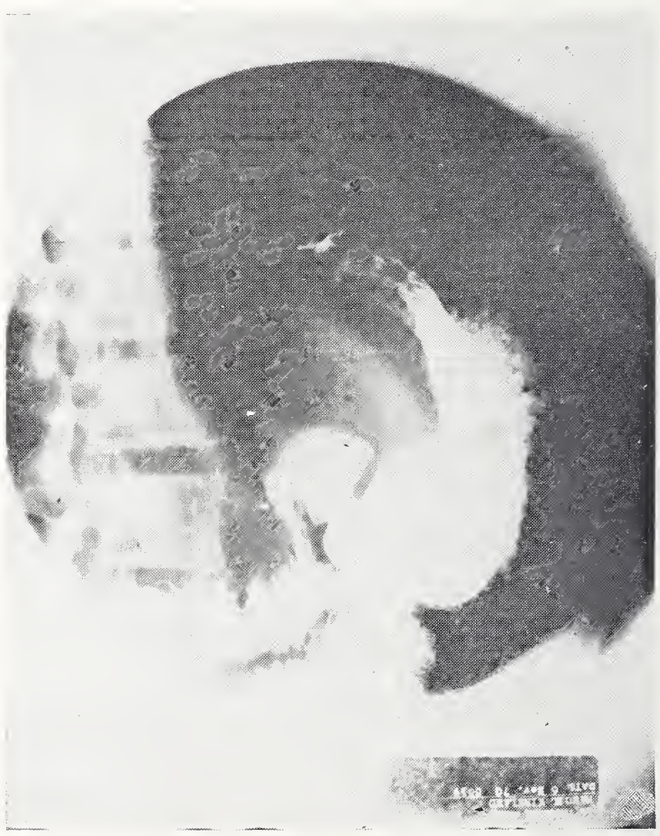


Figure 2



Figure 3



Figure 4

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NOT EXACTLY SCIENTIFIC

An exam question was to list four advantages of mother's milk.

One young med student wrote: "It's more nutritious. It's sterile. It's always the proper temperature." He couldn't think of the fourth one, so he added: "It comes in such cute little containers!"



The President Speaking

'The Task Ahead'

ARTHUR E. BROWN, M.D.
Columbus, Mississippi

THIS PRESIDENT'S PAGE is being written two weeks before the annual session to be held in Biloxi at which time the writer will be sworn in as president of the association. Since being elected president-elect last year, an attempt has diligently been made to acquaint myself with all phases of the association and its work. I have attended all Board of Trustees meetings, many committee meetings and several out-of-town meetings. I have come to feel the great dedication many members have for their association.

As the weeks and months have passed, it has become apparent to me that the task confronting us is too big for any one man, or for any committee or group of committees. It is a task that will require the support of all members of the state association working in unison. The ideas for revamping the medical care system in this country are too numerous to mention and new ones are being born almost daily. It is being said that we, the physicians, have not been keeping abreast of the rapid socioeconomic changes that are spreading through the country. But we are trying to study, analyze, consult, visit and make whatever changes which we feel we can without sacrificing the principles and ethics of our profession. The pressure is on and it will increase. The hour is late.

If we can present a united front, we as physicians can hold our heads high in the knowledge that we are the only ones who are able to deliver the high quality of medical care that is needed. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 6

JUNE 1971

EDITORIALS

Medicare and Mr. Mills: Shift in the Welfare Wind

I

MEDICARE is in for a revamping at the hands of the 92nd Congress. National health insurance or not, the solons will act, wielding the economy axe on runaway hospital costs by writing a bigger tab in cost-sharing for the beneficiary to pick up. What was generally considered to be indecisive failure on the part of the 91st Congress to enact any changes in the Social Security laws may have been a dress rehearsal for 1971's opening night. The production will be a spectacular.

There will be alterations in Medicaid, too, but it's odds-on that the basic structure and the major role of the states in program formulation and administration will, for the larger part, be basically unchanged. Cost-burdened state programs can expect little succor from a Congress that already has an administration budget with a programmed deficit of $14 billion and big city pork barrel vote bait euphemistically tagged revenue-sharing.

Rep. Wilbur Mills (D.,Ark.), chairman of the House Ways and Means Committee and held by not a few to be the most powerful individual in the Congress, seems to be paying little attention to the sound and fury over national health insurance in the Senate. Since the convening of the new Congress last January, Mr. Mills has devoted himself with singular purpose to taming rampant costs in Medicare. Nor is he insensitive to the fiscal chaos in which Medicaid wallows in a majority of the states.

On the Senate side, there is a tendency among proponents of national health insurance to sweep aside the Medicare-Medicaid problem by substituting a bigger one for it. But the man to watch is Chairman Mills who doesn't know how to lose.

II

The House Ways and Means Committee, surfacing with its revamping program after four months in executive session, is trying to wind down costs rather than radically revise the Medicare program. It is a practical, although an abrasive and painful approach, because it preserves the options for retaining the original Medicare structure or dumping it at a later and more propitious time.

Biggest slash would come in reducing the presently-authorized 59 days of impatient program-paid care to 14, if such major surgery can be sold to the Congress. From the 15th through the 60th day of hospitalization, the beneficiary would have to pay an eighth of the allowable hospital charges.

This represents a compromise with the administration's across-the-board slash of $450 million from funds for hospital care reimbursement. Mr. Mills' practical side is easily detected in this, too, because most short-stay patients would not have to ante up the co-pay share. This would still save an estimated $300 million, enough to compete successfully with the administration's cost-cutting plan, yet sparing most patients additional costs.

The deductible amount under Part B for physicians' services would be increased by 10 per cent to $55 from the original $50, and about the only expansionary aspect would be inclusion of the under-age-65 permanently and totally disabled in the program, a long-sought objective of both the Johnson and Nixon administrations.

And as in 1970, the House version has PSRO, Professional Standards Review Organizations, easily the most controversial part to physicians. But there is a change in direction with emphasis being placed on experimentation with a variety of review approaches. Through a separate mechanism of demonstration grants, medical association-sponsored care foundations, carrier-oriented mechanisms, and even government entities will all try their hands at quality evaluation of care and review.

The Mills theory is to try them all before structuring anything permanent into law. Short of realizing its legislative objective of enacting PRO, Peer Review Organizations, the AMA program could come into being through state medical association programs without a line of new legislation, the critical contingency being the success of medical care foundations.

III

Mr. Mills' path is not all light and sunshine, because two related issues are putting the pressure on the House of Representatives. One is the President's Family Assistance Program (FAP) under which welfare would become a total federal responsibility and the other is a pesky representative from upstate New York who insists that the government do what it said it would under Medicare.

Almost any enactment restructuring the welfare mess or bringing into being any form of NHI would drastically change or eliminate Medicaid. For many states, this would be good news, because most have had little but financial grief with their programs. Not so in a minority of the states, including Mississippi, where bare bones programs are tightly managed. The shift to a total federal program could likely bring discomfort to these few states as it inevitably blankets in more eligible recipients and superimposes federal criteria over those of the state.

Rep. Samuel Stratton (D.,N. Y.) has become something of a gadfly to HEW and especially to the Social Security Administration. He has made waves about Medicare paying only half of the cost of medical services, pointing with old fashioned honesty to the original provisions of Part B permitting payment of 80 per cent of such costs.

Mr. Stratton has introduced legislation to make SSA pay the freight under Part B, and he has aired a hitherto secret memo from SSA purporting to make further cuts in payments to physicians. The New York congressman says that he has caught the Social Security Administration "with its hand in the cookie jar."

Mr. Mills must contend with these ruts in the legislative road, but past performances suggest that he will at least find an acceptable accommodation if he can't wipe them out altogether.



"Well, your reflexes seem to be okay."

IV

The big three of NHI, AMA's Medicredit, the preposterous Kennedy health security package, and the American Hospital Association's Ameriplan, have widely differing approaches to the problems of Medicare and Medicaid. And for good reasons, too, because all three have equally divergent objectives.

Medicredit is a least-cost care financing mechanism within the private delivery system. The Kennedy program would out-socialize Scandinavia, and Ameriplan has been waggishly called a blueprint for Blue Cross survival with its Health Care Corporations.

Medicredit leaves Medicare undisturbed but wipes out Medicaid. Both the Kennedy and AHA plans would abolish both, yet they differ completely in the mechanics of how. If the Nixon FAP were enacted in the form proposed, it would increase the number of categorically indigent eligible for welfare benefits in Mississippi to 800,000 from the present 200,000. Without a drastic change in Medicaid, this could bankrupt Mississippi.

So of all alternatives, Medicredit is either the best of posssible worlds or the least of potential evils. Such drastic change may or may not come before the 1972 elections, but when and if it does, the nation must choose a more conservative path on health care financing or commit the nation to an all-out federal program. If Medicare is any bellwether, then Mr. Mills had better get on with the job.—R.B.K.

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The Pot Personality: It Really Exists

The legalize-pot cause got a slap and a setback with the recent publication of effects causally related to marijuana usage in the *Journal of the American Medical Association*. Seldom has a *JAMA* article received such widespread and well-deserved dissemination. Nor has one had such public impact.

Comes now a report of equal importance, not likely to comfort those who think that pot puffing isn't all bad. Dr. Norman Q. Brill and his associates at UCLA have found that some personality characteristics are correlated with regular marijuana use. The report, published in the *Archives of General Psychiatry,* said that the conclusions were drawn from studies of four user groups compared with two control groups.

The users consisted of 14 subjects who smoked pot every day, 19 who used it once or twice a week, 18 with once or twice per month habits, and 28 who said they used weed less frequently than monthly. The groups were rated on four scales of the Minnesota Multiphasic Personality Inventory: A risk-taking scale, a stimulus-seeking scale, nine specially constructed items, and a grouping of demographic variables.

The frequent users of marijuana rated high on the stimulus-seeking measure as well as on the MMPI psychopathic deviation scale. Frequent smokers made such responses as "a person should not be punished for breaking a law that he thinks is unreasonable."

While these studies focus upon still another aspect of marijuana usage from those of the adverse effects reported in *JAMA,* they demonstrate that the abnormal state of drug abuse may be sought as a refuge in personality defect. This is hardly a supporting argument for those who would legalize pot. Dr. Brill also discovered that regular marijuana use was significantly related to use of other drugs.—R.B.K.

Fewer Accidental Deaths in 1970

The data for 1970 accident mortality in the United States offer a little encouragement toward some few more of us dying from natural causes. About 113,000 accidental deaths were recorded last year, down 2,000 from 1969. The statisticians tell us that the provisional mortality rate from accidents for 1970 was 55.5 per 100,000, down from 57.0 in 1969.

The biggest gain was in motor vehicle fatalities where there were 1,100 fewer deaths in 1970 than the year before. This was the first downturn in four years and the best showing in 12 years. Mississippi was not so fortunate as the nation, for auto deaths in the state actually increased in 1970.

What is really encouraging about the fewer auto crash deaths is the cold fact that Americans drove more passenger miles in more automobiles than ever before. This has the net effect of making the life-saving decrease even greater.

The year 1970 was a perfect one for our domestic air lines with no passenger fatalities on the certificated scheduled carriers. The two football team tragedies were nonscheduled charter and special air line charter.

Seven major catastrophes, defined as taking 25 lives or more, were posted in 1970. In addition to the two aviation occurrences, there were the Wooten, Ky., coal mine explosion which killed 38, the Marietta, Ohio, nursing home fire claiming 31, the Tucson, Ariz., hotel conflagration with 28 deaths, and two Texas tornadoes with 51 fatalities.

Job-related fatalities were about the same as 1969 with 14,200 deaths of which a fifth were in auto crashes. And there was no place like home where 27,000 met death in accidents, nearly half of them children. Fewer accidental deaths were caused in 1970 in civil aviation, military air operations, and water transportation.

Safety and prevention pays handsome dividends in lives saved. A share of the credit for the better record belongs to the medical profession, both for curative procedures preventing death after accidents and for accident prevention programs carried on by medicine.—R.B.K.

Liability Precedent for Public Health

Our colleagues in preventive medicine are usually considered as being less susceptible to professional liability suits than physicians in other specialties. Yet, suits can be and are filed against public health physicians with increasing frequency. It is not all this grave, for these specialists are still able to command the lowest premium structure for coverage of any of their colleagues.

A recent case decided in New York offers even further protection for the public health physician. An old law providing that the state should indemnify and hold harmless its employee physicians from malpractice claims was tested when a public health officer was sued for negligence in furnishing services in the course of his official duties.

The court held that the government has a duty not only to indemnify him and hold harmless but also to provide for his defense. This revises substantially the practice of the state waiting until judgment had been entered against a public health physician and then merely picking up the tab. This, in effect, rounds out full protection for the doctor under terms of employment in New York.



Application of the precedent in other states may depend upon the terms of employment of public health physicians. Its significance may be further underscored by the bringing into play the greater legal defense resources of a state and the assurance that these will usually exceed private defense resources. The citation is *Stephens v. Department of Health of Orange County, 317 N.Y.S. 2d 210 (N.Y. Sup. Ct., 1970).* This is a significant precedent worth watching.—R.B.K.



PERSONALS

O. J. Andy and Bernard S. Patrick of Jackson attended the 39th annual meeting of the American Association of Neurological Surgeons in Houston.

Loren Breland, L. D. Turner, Donald A. Hopkins, W. Moncure Dabney, and Jerry B. Gulledge, all of Crystal Springs, were honored with a dinner party in the home of Dr. and Mrs. Jerry Gulledge on Doctor's Day, March 30.

R. T. Dabbs of Aberdeen was guest speaker at the West Point Rotary Club's monthly meeting. Dr. Dabbs gave a presentation of the use of hypnosis in medical treatment and obstetrics.

John T. Davis and Charles H. Martin of Natchez are in charge of arrangements for the UMC circuit course series for postgraduate education in Natchez during 1971.

Thomas M. Davis of Jackson has announced that he is a candidate for Hinds County coroner. Dr. Davis has qualified with the Republican Party for the fall elections.

Marian W. Godbey of Aberdeen and Robert E. Schwartz of Hattiesburg have been elected to three-year terms on the Mississippi Tuberculosis and Respiratory Disease Board of Directors. Continuing to serve terms are Guy Campbell, Hugh B. Cottrell, and John F. Busey of Jackson and Clyde A. Watkins of Sanatorium.

G. Swink Hicks of Natchez retired from the board of trustees of Mississippi Hospital and Medical Service recently at the annual meeting in Jackson. Dr. Hicks was presented an engraved desk set in appreciation for his service to Blue Cross-Blue Shield in Mississippi.

Wendell B. Holmes of McComb announces the removal of his offices to 300 Marion Drive, across from Southwest Mississippi General Hospital.

T. D. Lampton of Jackson was guest speaker at the Tylertown Rotary Club meeting in April. Dr. Lampton, a native of Tylertown, discussed the work of the Mississippi Regional Medical Program.

Thomas Dale Little of Meridian was guest speaker at the annual dinner meeting of the Lauderdale County Tuberculosis and Respiratory Disease Association. Dr. Little limits his practice to orthopedic surgery.

John A. Marascalco of Greenville and Ellis M. Moffitt of Jackson were guest speakers at the semi-annual meeting of the Clarksdale and Six Counties Medical Society in Clarksdale.

Charles L. Neill, Jr., of Jackson is serving as a commissioner for the Jackson Municipal Airport Authority.

W. R. Peebles of Union was presented with a maple desk by the employees and staff of Laird Hospital and Clinic at a farewell party. Dr. Peebles has retired from the active practice of medicine and is moving to his hometown, Henry, Tenn.

Roland B. Robertson of Jackson has been elected president of the Mississippi Thoracic Society, medical section of the Mississippi Tuberculosis and Respiratory Disease Association. G. Boyd Shaw of Jackson was elected vice president, Fred Tatum of Hattiesburg, secretary-treasurer; and Guy Campbell of Jackson, Mississippi Thoracic Society Representative Councilor to the American Thoracic Society.

Frank O. Schmidt was presented a retirement gift by the Ocean Springs Hospital Auxiliary, medical staff and hospital employees at a special coffee honoring area physicians on Doctor Appreciation Day.

Donald M. Sherline of Jackson participated in the April sessions of the Society of Obstetrical Anesthesiologists and Perinatologists in Atlanta.

James P. Spell of Jackson presented the program before the General Earl Van Dorn Camp, Sons of Confederate Veterans at the monthly noon luncheon at the University Medical Alumni House. His topic was "Civil War Medicine."

MAURICE A. TAQUINO of Biloxi has been re-elected district chairman of the Harrison County Heart Association. HARRY J. SCHMIDT of Biloxi is the new medical representative of the group.

CLIFFORD TILLMAN of Natchez has been elected medical representative of the Adams County Heart Association.

WALTER TREADWELL and WILLIAM LOCKWOOD of Jackson were guest speakers for the seminar on inhalation therapy at Southwest Mississippi General Hospital in McComb.

DAVID VANLANDINGHAM of Jackson has been named by the R. H. Green Foundation to represent the foundation in its dealings with Mississippi Baptist Hospital. The foundation, which has made a series of gifts to the hospital, was organized in 1937 to help provide hospitalization for indigent blacks in the Jackson area.

DAYTON E. WHITES of Lucedale has been elected medical representative of the George County chapter of the Mississippi Heart Association.

NEW MEMBERS

LLOYD, JUDSON FRANK, Natchez. Born New York City, Dec. 22, 1934; M.D. Siriraj Medical School Hospital, Bangkok, Thailand, 1962; interned same one year; surgery residencies Mt. Carmel Hospital, Columbus, Ohio, June 1, 1963-June 30, 1964; V.A. Hospital, Minneapolis, Minn., July 1, 1964-April 28, 1966; Virginia Mason Hospital, Seattle, Wash., May 15, 1968-June 13, 1969; and Watts Hospital, Durham, North Carolina June 16, 1969-June 30, 1970; elected Oct. 1970 by Adams County Medical Society.

LOWE, C. FOSTER, McComb. Born Winona, Miss., Dec. 14, 1935; M.D. University of Mississippi School of Medicine, Jackson, Miss., 1960; interned The Medical Center, Columbus, Ga., one year; surgery residency University Medical Center, Jackson, Miss., July 1, 1966-June 30, 1970; elected Jan. 1, 1971 by South Central Medical Society.

PRICE, E. J., JR., McComb. Born McComb, Miss., Sept. 20, 1939, M.D. University of Mississippi School of Medicine, Jackson, Miss., 1964; interned Brooke General Hospital, San Antonio, Texas, one year; Ob-Gyn residency University Medical Center, Jackson, Miss., July 1, 1967-June 30, 1970; elected Jan. 1, 1971 by South Central Medical Society.

RUBIO, ANTONIO M., Meridian. Born Guane, Cuba, Sept. 26, 1925; M.D. University of Havana School of Medicine, Havana, Cuba 1949; psychiatry residency University Virginia Hospital, Charlottesville, Va., July 1, 1963-June 30, 1967; elected Feb. 2, 1971 by East Mississippi Medical Society.

RUTLEDGE, LEWIS JAMES, McComb. Born McComb, Miss., April 24, 1924; M.D. Tulane University School of Medicine, New Orleans, La., 1947; interned Charity Hospital, New Orleans, La. one year; pediatric residency same 1948-50; otolaryngology residency same 1955-57; elected Jan. 1, 1971 by South Central Medical Society.

DEATHS

No reports of deaths of members of the association and physicians in Mississippi were reported to the JOURNAL during May 1971.

IRS Changes Filing for Estate Tax

J. G. Martin, Jr., district director of Internal Revenue Service, has reminded taxpayers that filing dates for estate tax returns were changed by The Excise, Estate, and Gift Tax Adjustment Act of 1970.

Effective for the estates of decedents with date of death after Dec. 31, 1970, an estate tax return is required to be filed within nine months after the date of a decedent's death. Since the estate tax is still payable with the return, the time for paying the estate tax is also nine months.

The alternate valuation date is shortened from 12 months to six months. In addition, an 80-year old holder of a power of appointment has nine months instead of 12 months within which to execute the affidavit specifying that he intends to execute his power of appointment in favor of a charity.

The estates of decedents with date of death before Jan. 1, 1971, are governed by the old rules as to filing (15 months), the alternate valuation method (one year), and exercise of the power of appointment charitable in favor of charity (one year).

Book Reviews

The Adolescent Patient. By William A. Daniel, Jr., M.D. 444 pages with 76 illustrations. St. Louis: The C. V. Mosby Company, 1970. $20.50.

In this text of some 429 pages, Dr. Daniel has assembled and arranged a fairly comprehensive group of individual treatises on the major aspects of adolescent medical care and rehabilitation, and thereby has provided the best presentation to date on the subject. Principal areas covered include an introduction by Dr. Daniel himself with a down-to-earth and practical approach to the adolescent patient, general comments on growth and development in both the physical and emotional spheres, and an excellent section on the adolescent in relation to today's society; medical problems of the adolescent patient are then discussed; and finally an exhaustive discussion of communication disorders and rehabilitation of the chronically disabled child rounds out the volume.

It seems that the editing was somewhat spotty and would have profited from more treatment from Dr. Daniel himself, whose personally authored sections are definitely good reading from a professional and a humanistic standpoint. His understanding and empathy for the teenager show through vividly, and he clearly renders the patient himself the logical target for professional interest and effort with a minimum of verbosity or sidetracking.

On the other hand, the sections written by contributing professionals are quite variable in their quality of information and presentation, among the best being the chapters on dental care (rarely seen in a general medical text), renal disorders and hypertension, genetic disorders, and endocrine diseases. Rating somewhat lower in content and value are the sections on nutrition, infectious diseases, and diabetes, with the last mentioned area devoted largely to calculation of caloric needs, certainly one of the least of many problems to deal with in the care of the adolescent diabetic!

The final section of this volume somewhat exceeds its expected value in the extensive detail with which it tends to treat the chronic problems of sensory and motor disabilities, primarily institutional disorders seldom handled in such comprehensive fashion by the practitioner who sees the adolescent.

Some inconsistencies notwithstanding, this text on the overall care of the adolescent is probably the best yet printed on the subject, and until the still unfulfilled need for a large comprehensive work on adolescent medicine is satisfied, *The Adolescent Patient* can provide valuable insight to the practitioner who desires to gain more medical expertise and rapport with the teenage patient in his practice.

William A. Long, Jr., M.D.

Healers in Uniform. By Edward Edelson. 184 pages. Garden City, New York: Doubleday and Company, 1971. $3.95.

In this well written little volume are fascinating stories of the lives and work of 12 of the giants of American medicine. These were 12 of the most heroic military medical men in the history of the United States Armed Forces.

Among these was William Beaumont who treated the Canadian voyageur, Alexis St. Martin, for the famous shotgun wound which healed leaving an opening directly into St. Martin's stomach. Beaumont's studies of gastric digestion constituted the first significant contribution to medical research made by an American. Beaumont's problems with the sometimes uncooperative Alexis add much to the human interest side of this great story.

Walter Reed's conquest of yellow jack and Bailey K. Ashford's victory over the "laziness bug" hookworm disease provide great reading. Also included are descriptions of the establishment of the first blood bank by Oswald H. Robertson in WWI. As has happened so many times before, this lesson was forgotten and had to be relearned.

David N. W. Grant's fight for air evacuation for the wounded and William Randolph Lovelace's personal contributions to the physiology of man's adaptation to high altitudes which served as a basis for space medicine are included. Benjamin Rush, the Revolutionary War surgeon, personally contributed much to military preventive medicine. As Surgeon General, Dr. Rush found that he was caught in a feud between two con-

temporaries, John Morgan and William Shippen, Jr. Benjamin Rush was so discouraged at the state of the health of the Army that at one time he appealed to Patrick Henry suggesting that George Washington be relieved. Rush later regretted this action and apparently pleaded successfully to have any menton of his criticism of Washington omitted from the biography of our first president.

This is a small volume that will appeal not only to the physician and his family, but to all individuals who are deeply concerned with humanity.

ROBERT E. BLOUNT, M.D.

Connecticut Society Gets Insurance Program

An Aetna Life & Casualty proposal to provide a professional insurance program for the 3,800 members of the Connecticut State Medical Society has been accepted by the Society's House of Delegates.

The plan, developed jointly by Aetna and CSMS, is the most comprehensive program yet devised for a medical society. It consists of a package of normally separate property and liability coverages designed to assure the Society's members access to a total professional insurance program on a long-term basis. It will be made available to CSMS members in the fall through their local Aetna agents.

The plan, which will be coordinated through a full-time Aetna administrator, features a number of special measures. To speed claim payments and assure the highest possible standards of medical care, committees administered jointly by Aetna and CSMS will review all cases involving possible professional liability from medical, legal and educational standpoints.

Also, in an effort to control insurance costs and thus medical costs to the public, expenses and claim payments will be reviewed annually and dividends may be declared by Aetna's board of directors.

Included in the program are professional and office premises liability coverages and catastrophe insurance that exceeds basic coverages. In addition, as an option, professional equipment coverage is available.



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Dr. Brown Is Inaugurated President, Dr. Jenkins Is Named President-elect

Dr. C. R. Jenkins of Laurel was named president-elect of the association at the closing meeting of the 103rd Annual Session, and Dr. Arthur E. Brown of Columbus was inaugurated 1971-72 president, succeeding Dr. Paul B. Brumby of Lexington.

The four-day meet was headquartered at the new Sheraton-Biloxi and featured seven general scientific sessions, meetings of 12 specialty societies, and medical alumni and social occasions. More than 40 essayists presented a varied program which drew praise of registrants.

The Coast annual session had a registration of 904 which included 420 members, 86 M.D. guests, 20 residents, and five medical students. Others included 73 nonphysician guests, 75 exhibitors, 215 Auxiliary members, and 10 staff.



Three years of the association's presidency are represented by, from left, Drs. C. R. Jenkins, the new president-elect, 1972-73; Arthur E. Brown, 1971-72; and Paul B. Brumby, 1970-71.

Handling a record business agenda, the House of Delegates acted on 31 reports, 11 of which were from the Board of Trustees, and 11 resolutions, including one carried over from 1970. Five reference committees conducted hearings before which large numbers of members and guests appeared for discussion and debate.

Dr. Paul B. Brumby addressed the opening meeting of the House on May 3 on health care delivery with emphasis on medical care foundations. He urged creation of a foundation in Mississippi into which would be incorporated peer review.



Dr. Walter C. Bornemeier of Chicago, president of the American Medical Association, appeared as principal guest speaker of the annual session. He addressed the House of Delegates at opening meeting.

The 1970-71 president said that the new legislative program was one of the most successful in the association's history, and he commended the membership for grass-roots support. He also mentioned national legislation and the threat of total government intervention in health care delivery which he said must remain under medical control.

Sharing the rostrum spotlight with Dr. Brumby was Dr. Walter C. Bornemeier of Chicago, president of the American Medical Association, who stressed manpower and utilization of health care facilities in his address.

A gift of $10,820 was made to the University Medical Center by the state association's AMA-ERF campaign.

New vice presidents named to serve in 1971-72 are Drs. Benton M. Hilbun of Tupelo, John G. Atwood of Meridian, and O. D. Dabbs of Gulfport.

Dr. Thomas W. Wesson of Tupelo was re-elected associate editor of the JOURNAL.

Named to another two-year term as AMA delegate was Dr. G. Swink Hicks of Natchez, and the House re-elected Dr. Joseph B. Rogers of Oxford alternate delegate to AMA.

Delegates, tallied at 101 in the May 6 balloting, elected Dr. Brumby District 4 Trustee to succeed Dr. Mal S. Riddell, Jr., of Winona who had served the maximum of three consecutive terms and was not eligible for re-election. The new Trustee for District 5 is Dr. James L. Royals of Jackson, succeeding Dr. William O. Barnett, also of Jackson. Dr. Guy T. Vise of Meridian succeeded himself as District 6 Trustee.

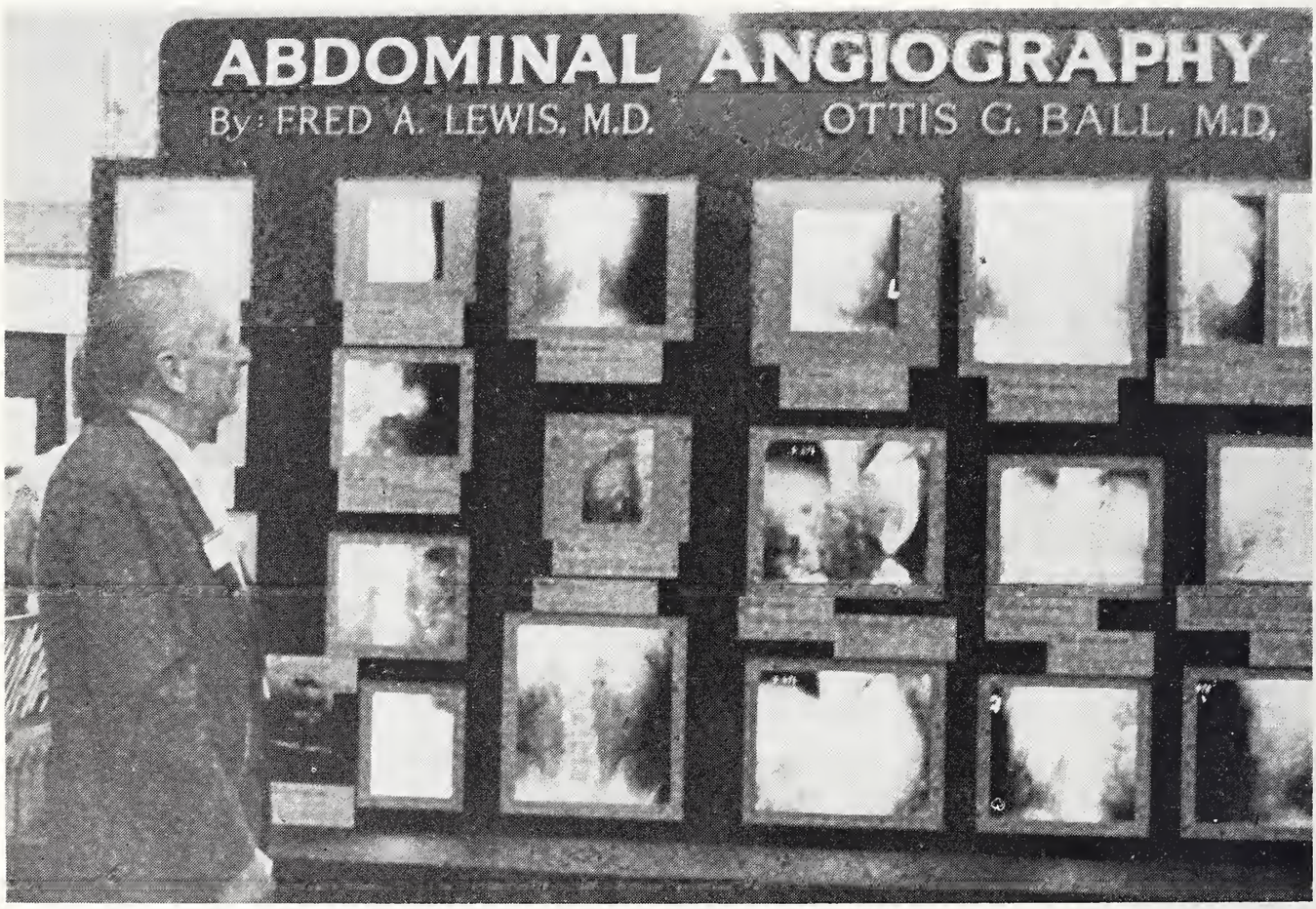
Elected to the Council on Budget and Finance were Drs. James O. Gilmore of Oxford, Walter H. Rose of Indianola, and Jack A. Atkinson of Brookhaven. The former three-member body was expanded by two seats in a 1970 action to be effective this year.

Dr. Raymond S. Martin, Jr., of Jackson was re-elected to the Council on Constitution and By-Laws. Named to the Judicial Council were Drs. John G. Egger of Drew, John R. Lovelace of Batesville, and Dr. Frank M. Davis of Corinth.

New members of the Council on Legislation are Drs. Walter H. Rose of Indianola, T. L. Ketchum of Ripley, and William H. Preston, Jr., of Booneville.

Dr. Carl G. Evers of Jackson was elected to the Council on Medical Education while Drs. Edward Pennington of Ackerman, Tom H. Mitchell of Vicksburg, and William M. Gillespie, Jr., of Meridian were named to the Council on Medical Service.

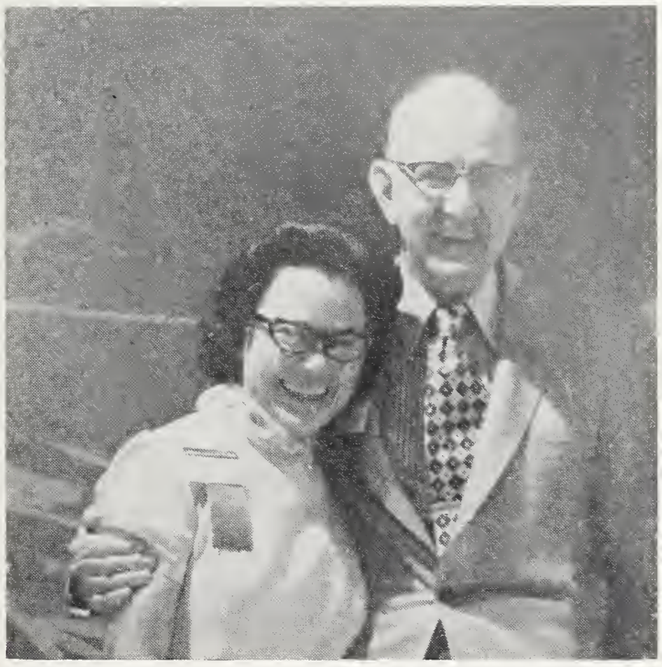
Nominees to the State Board of Health from Public Health District 6 are Drs. Bedford F. Floyd of Gulfport, Joseph G. McKinnon of Hattiesburg, and William E. Weems of Laurel.



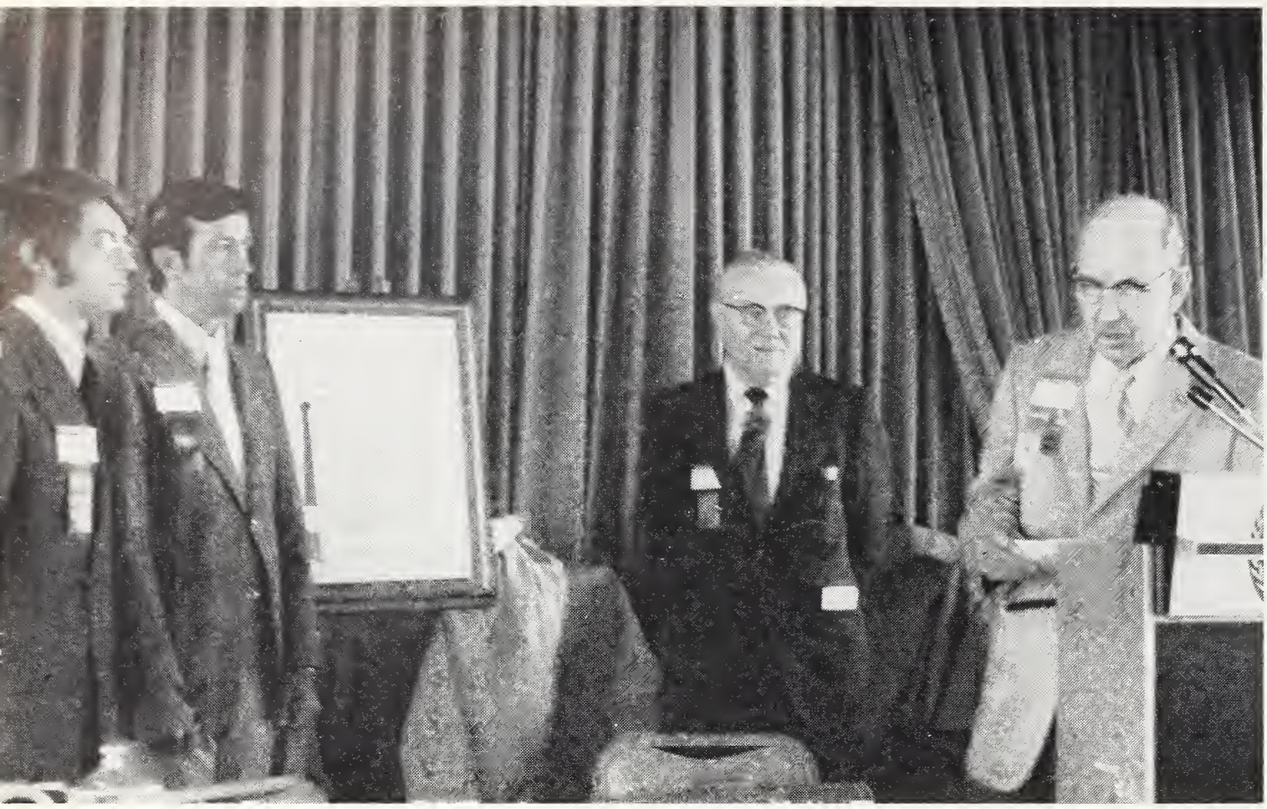
Dr. Hugh B. Cottrell, State Health Officer, studies the winning scientific exhibit, "Abdominal Angiography," by Drs. Ottis Ball and Fred A. Lewis of the Mississippi Baptist Hospital department of radiology. The authors received the Aesculapius Award cash honorarium for best exhibit by a member.



Delegates and officers ponder over wealth of reports and resolutions introduced in the House of Delegates. Left, it was the official presidential hug as Dr. Brumby embraces Mrs. Curtis Caine of Jackson, Auxiliary president. Right, Mrs. T. E. Ross, III, of Hattiesburg addresses House as she assumes Auxiliary presidency for 1971-72.











The University Medical Society was officially chartered in the House of Delegates by Drs. Brumby and Bornemeier, presidents of MSMA and AMA, respectively. Mr. W. J. Gibson, Jr., of West Point, far left, society president, and Mr. Paul B. Welch of Laurel, delegate from the society, accepted the charter. Left, Dr. John B. Howell, Jr., of Canton presided over the House of Delegates as speaker. Lower left, Dr. Stanley A. Hill of Corinth, Speaker Pro Tem, follows floor discussion as he presides.



Members of the Fifty Year Club at annual session participated in a special luncheon meeting. Club "officers" were Board Chairman Riddell, at head of table, and Barbara Shelton, association director of administrative services who serves as club secretary.

For Public Health District 7, the delegates nominated Drs. William M. Dabney of Crystal Springs, R. J. Field, Jr., of Centreville, and G. Swink Hicks of Natchez.

Drs. Wilfred Q. Cole of Jackson, H. C. Ricks, Sr., of Jackson, and E. L. Whitfield of Florence were nominated for the seat in Public Health District 8.

Incumbents on the Board of Health are Drs. McKinnon, Hicks, and Ricks. The Governor makes the appointments from among nominees named by the association for eight of the 11 seats.

Delegates Act on Major Issues at Biloxi

Repeal of mandatory AMA dues, creation of the Mississippi Foundation for Medical Care, chartering of the new University Medical Society, and a call for a state medical examiner highlighted a heavy agenda of 31 reports and 11 resolutions acted on by the House of Delegates.

Hearings were conducted by reference committees before which discussion and debate were heard on Monday, May 3. The committees reported to the House at the Thursday adjourned meeting on May 6 where floor action took place, also with full discussion and debate.

Resolution No. 4 by the Central Medical Society was passed repealing mandatory AMA dues beginning with the 1972 association year. Premise of the resolution was that "many physicians conscientiously believe that they should be free to make a decision on AMA membership as individuals without coercion, compulsion, or penalty against their component society and state medical association membership."

Mississippi was one of only nine states with the requirement. In taking the action, the House urged every member of the Mississippi State Medical Association "to weigh conscientiously the merit and value of AMA membership" as voluntary payment of dues to medicine's parent body was encouraged.

The Board of Trustees was authorized and empowered to create the Mississippi Foundation for Medical Care under sponsorship and control of the association. The foundation will oversee administration of medical care plans and will have legal status in concluding contracts to represent

physicians in processing claims for services rendered.

The foundation will be governed by a board of physicians named by the association, and the present headquarters building will house the staff which will be made up of many of the present members together with additional ones required.

Costs of operating the foundation are realized from nominal charges to third parties in processing claims and conducting physician-sponsored peer review.

Participation in the foundation will be voluntary, and membership or nonmembership cannot and does not affect practice status, professional prerogative, or membership in medical organization. Medical care foundations are operating successfully in more than a dozen states, all under medical association sponsorship and control.

In debate, an effort to delay creation of the foundation pending further discussion and information programs was defeated after an hour's discussion.

President Brumby and AMA President Walter C. Bornemeier jointly conducted chartering ceremonies for the new University Medical Society, the component for junior and senior medical students at UMC. Society delegates William J. Gibson, Jr., of West Point, also president of the group, and Paul B. Welch of Laurel accepted the charter at the opening meeting.

The House approved creation of the office of state medical examiner who must be a qualified forensic pathologist. The original resolution, sponsored by the Mississippi Association of Pathologists, was modified to require that the examiner be located at the University Medical Center where he may also engage in teaching. The House suggested the possibility of the medical center establishing a Department of Forensic Medicine.

In other actions, the delegates voted to extend association sponsorship to Mississippi Health Expo I, slated for the Coliseum at Jackson Oct. 1-3, 1971. Mrs. Guy T. Gillespie of Jackson addressed the House in behalf of the project which promises to be the greatest single health education effort in the history of the state.

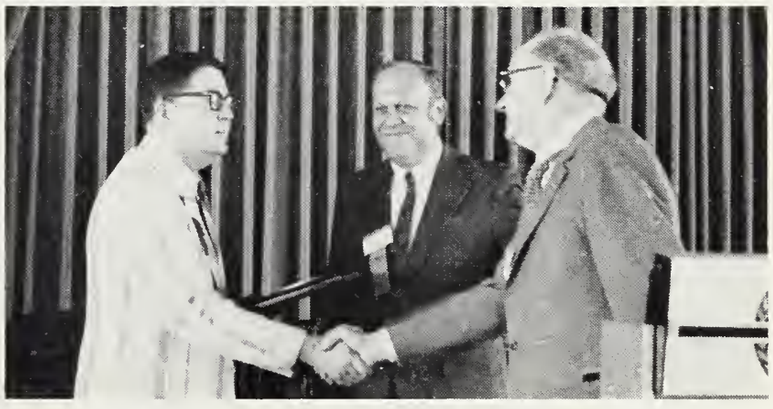
The House reviewed and approved the new and expanded legislative program which was authorized and financed in 1970 at the same time the new peer review program was created. Both drew praise from the policy-making body.

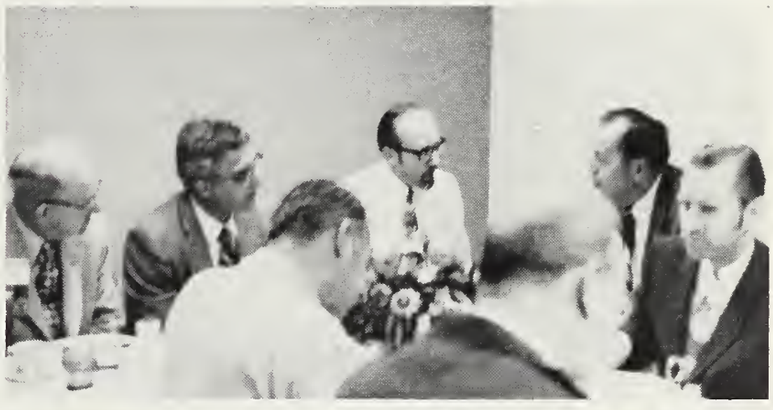
Acting on a resolution introduced by the student delegates, the House strongly urged establishment of a Department of Family Practice at the University Medical Center for training family practice specialists. The action also called for



Dr. C. R. Jenkins of Laurel chaired the Reference Committee on Reports of Officers and Board of Trustees which heard a full house of officers, members and guests discuss the various reports and resolutions referred to it.









Past presidents of the association enjoy fraternal and traditional breakfast with special guests, Drs. Brumby and Brown, candidates for select circle. Right, Dr. Walter H. Rose of Indianola was winner of 1971 MSMA-Robins Award for outstanding community service by a physician. President Brumby and Mr. Willard Duvall, district manager of the Robins Company, congratulate the honoree. Middle right, members of the Committee on Medicine and Religion met for a breakfast occasion with special guests, Mr. Arne E. Larson of Chicago, director of the AMA department of Medicine and Religion, and his associate, Mr. William Hoffman. Lower right, MSMA staff registered a whopping 904 members, guests, auxiliary and exhibitors during the 103rd annual session.

family practice residencies, and for coordinated support by the Board of Trustees, Council on Medical Education, and Council on Legislation.

Another key action was adoption of a resolution opposing the restrictive FDA policies on combination ingredient drug products, "thereby denying the physician and his patient the convenience and economy of many proven products." The House approved a statement that such action was a usurpation of medical practice, a needless increase in the cost of drugs to the patient, and a waste of research and clinical manpower, facilities, and expense in satisfying these restrictive requirements.

The House adopted a floor-sponsored substitute action in recommending that the state of Mississippi provide professional liability insurance for public health physicians. The original resolution called for the state to defend, indemnify, and hold harmless a public health physician in event of suit for malpractice arising out of performance of his official duties.

In other actions, the House of Delegates:

—Commended President Brumby for serving with dedication, diligence, and enthusiasm.

—Expressed appreciation to Dr. Raymond S. Martin, Jr., of Jackson for effective service as secretary-treasurer and chairman of the Council on Scientific Assembly.

—Sent good wishes to Dr. William E. Lotterhos of Jackson, speaker of the House, who was absent convalescing from recent surgery.

—Applauded the work of the 1970 AMA delegates, Drs. G. Swink Hicks of Natchez and Stanley A. Hill of Corinth.

—Transferred Union County, upon petition of all members in the area, to the Northeast Mississippi Medical Society from the North Mississippi Medical Society.

—Called outstanding the work of the Committee on Peer Review and took notice that its

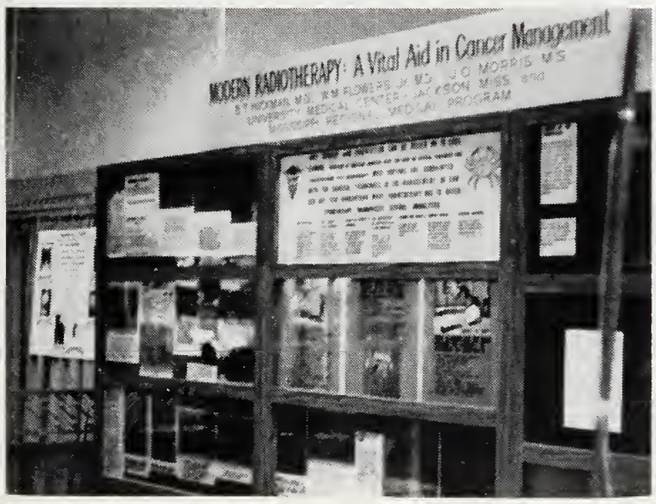


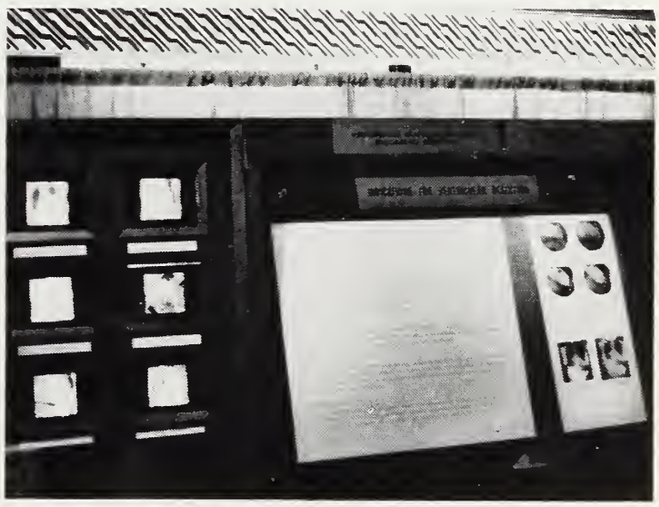
The Woman's Auxiliary, meeting concurrently for its 48th annual session, elected new officers for 1971-72. From left standing are, Mesdames Henry Webb, treasurer; R. A. Little, third vice president; Joe D. Herrington, recording secretary; Jack A. Stokes, second vice president; Jack B. Campbell, fourth vice president; and seated from left, Clarence H. Webb, Jr., president-elect; T. E. Ross, III, president; and W. H. Preston, Jr., first vice president.



Dr. Brown is inaugurated 1971-72 president as Executive Secretary Rowland B. Kennedy holds association's historic Bible and Board Chairman Riddell administers oath of office. Right, President Brumby congratulates president-elect Jenkins as Board Chairman Riddell looks on. Lower left, second place winner in the scientific exhibit competition was "Modern Radiotherapy: A Vital Aid in Cancer Management," by Drs. B. T. Hickman, W. M. Flowers, and J. O. Morris from the UMC department of radiology. Winner of the gold medallion for best scientific exhibit by a nonmember was "Ventricular Resection Following Myocardial Infarction," by Drs. Hector S. Howard, H. Edward Garrett, and J. T. Davis, Jr., of Memphis.











Left, new officers for the Mississippi Society of Internal Medicine are from left, Dr. G. Spencer Barnes of Columbus, president; Dr. S. H. McDonnieal, Jr., of Jackson, secretary; and Dr. John R. Shell of Vicksburg, president-elect. Right, Mississippi Urological Society past president Dr. W. J. Slaughter of Meridian shows the ropes to new officers Dr. Charles D. Scruggs of Jackson, president, and seated, Dr. W. H. Merrell, Jr., of Jackson, secretary-treasurer. Lower left, the Mississippi chapter of the American College of Surgeons elected a new slate at its luncheon meeting. From left are Drs. A. L. Meena, secretary-treasurer, W. C. Shands, president, and Raymond S. Martin, Jr., president-elect. All are from Jackson. The Mississippi Association of Pathologists 1971-72 officers are from left, Drs. W. D. Atchison, president-elect; T. S. Rodda, president; Roland F. Samson, secretary; Catherine G. Goetz, treasurer; and Carl G. Evers, past president.







Dignitaries at the head table enjoy the seafood jamboree and dance put on by the Ole Miss Medical Alumni chapter. Chairmen of the reference committees report to the House of Delegates at its concluding session. From lower left, they are Drs. James T. Thompson, chairman of the Nominating Committee; William H. Preston, Jr., chairman of the Reference Committee on Miscellaneous Business; and E. L. Whitfield, chairman of the Reference Committee on Rules and Order of Business.







program would be incorporated into that of the Mississippi Foundation for Medical Care.

—Scheduled the 1972 annual session for the Gulf Coast at the new Sheraton-Biloxi May 8-11 and took options with the luxury convention facility for 1973, 1974, and 1975.

—Approved a program of records-keeping and certification for postgraduate or continuing education credit for Mississippi physicians by the executive office, including certification to AAGP, AMA, and other societies.

—Set policies for physicians' assistants and asked the Council on Medical Education to develop training minimums for this new field of skilled professional manpower.

—Directed that policies be developed for graduate nurse midwives or obstetrical assistants by the Council on Medical Education.

—Thanked the Mississippi Hospital Association for the productive joint liaison program carried out in 1970-71.

—Gave support to the summer extern program developed in partnership with the state hospital association, Student AMA chapter at UMC, and 28 Mississippi hospitals who will accept 40 externs this summer.

—Urged support for a 10-year, $185 million capital improvement program for the University Medical Center and the eight senior colleges and universities of the state and heard Chancellor Porter Fortune of Ole Miss and Sen. Corbett Patride of Schlater support the move.

—Praised the work of the Council on Scientific Assembly on the excellent scientific program.

—Urged universal voluntary participation in AMA-ERF by the membership in supporting medical educational institutions of their choice by earmarking gifts contributed through the program.

—Mandated licensure of child care centers, asking association sponsorship of legislation in 1972.

—Ordered that wide publicity be given the Emergency Health Personnel Act of 1970 as a means of relieving acute physician shortages.

—Created, by amendment of the By-Laws, a five-member Committee on Long Range Planning to "assess developments and requirements in fields of association activity, making recommendations for courses of action to achieve maximum possible effectiveness. . . ."

—Conferred approval on the extensive program of the Council on Medical Service and expressed satisfaction over a study of physician participation in Medicaid performed for the legislature.

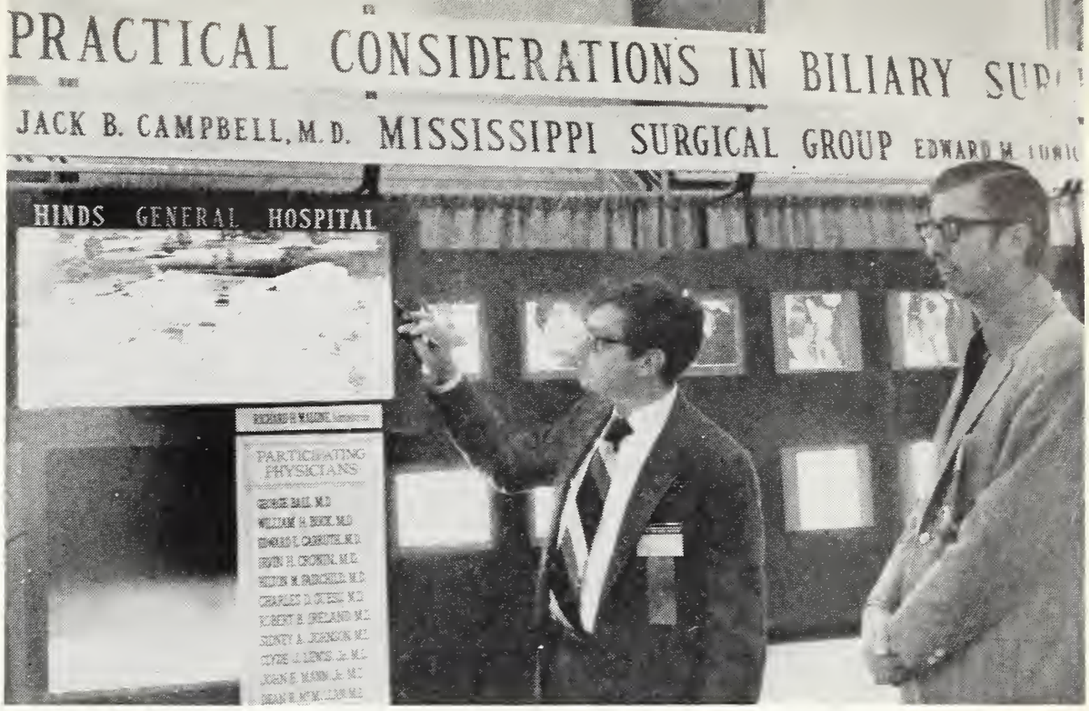
—Referred the Report of the Governor's Committee on Children and Youth to the Board of



Dr. Raymond S. Martin, Jr., association secretary-treasurer, presided over the Council on Constitution and By-Laws as it considered such vital issues as mandatory AMA dues.



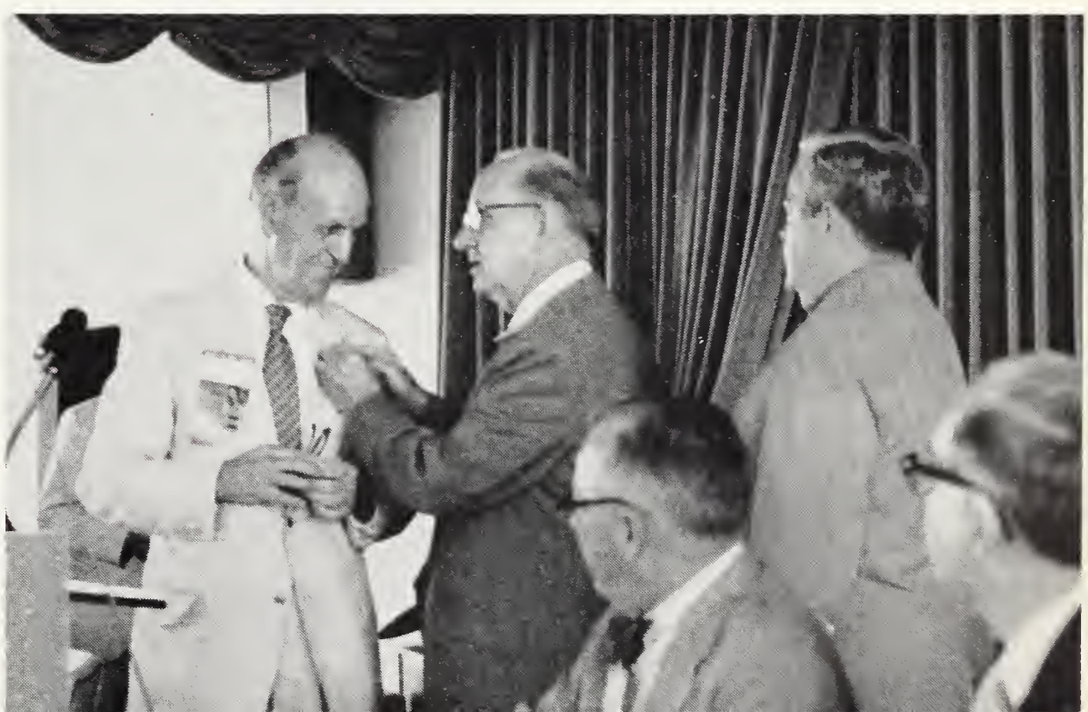
Mr. Arne E. Larson of Chicago, director of the AMA Department of Medicine and Religion, was a guest at the Committee on Medicine and Religion breakfast. He was also special guest speaker before the Woman's Auxiliary.



Discussing highlights of their scientific exhibit, "Practical Considerations in Biliary Surgery," are Drs. Edward M. Lowicki, at left, and Jack B. Campbell of Jackson. At near right, new chairman of the MSMA section on surgery is Dr. W. Lamar Weems of Jackson. Dr. James C. Totten, Jr., of Pascagoula will chair the section on Preventive Medicine for 1971-72. Lower right, Dr. Arthur E. Brown of Columbus, after being sworn in as 1971-72 president of the association, receives his president's pin.







Trustees with a request for re-referral to appropriate bodies of the association.

—Called on component medical societies to appoint Committees on Medicine and Religion and to initiate physician-clergyman dialogue at the local level.

—Changed the parliamentary standard of the House of Delegates to *Sturgis Standard Code of Parliamentary Procedure* from *Robert's Rules of Order, Newly Revised,* an action proposed in 1970 by Dr. Howard A. Nelson of Greenwood in a resolution laid on the table for a year.

The delegates were in session on May 3 and 6 with reference committee hearings on the first day in the afternoon. The Reference Committee on Credentials reported seating 108 delegates on May 3 and 103 delegates on May 6.

Reference committee chairmen serving were Drs. C. R. Jenkins of Laurel, Reports of Officers and Board of Trustees; James M. Dabbs of Waynesboro, Medical Practices; William H. Preston, Jr., of Booneville, Miscellaneous Business; Raymond S. Martin, Jr., of Jackson, Constitution and By-Laws; J. T. Davis of Corinth, Budget and Finance; and E. L. Whitfield of Florence, Rules and Order of Business.

Board of Trustees Names 1971-72 Officers

Two new names appear on the roster of the association's nine-member governing body, the Board of Trustees. Elected for three-year terms by the House of Delegates were Drs. Paul B. Brumby of Lexington for District 4 and James L. Royals of Jackson, representing District 5.



Dr. Davis

Dr. Guy T. Vise of Meridian was re-elected to a three year term.

Dr. J. T. Davis of Corinth was named Board chairman, succeeding Dr. Mal S. Riddell, Jr., of Winona who retired from the body after serving the constitutional maximum of nine years or three terms.

Dr. Everett Crawford of Tylertown is the vice chairman, and Dr. Royals was elected Board secretary. The chairman, vice chairman, and secretary make up the Executive Committee.

Continuing to serve are Drs. Lyne S. Gamble of Greenville, District 1, James O. Gilmore of Oxford, District 2, W. E. Moak of Richton, District 7, and James T. Thompson of Moss Point, District 9.

Drs. Davis and Crawford respectively represent District 3 and 8. Dr. Royals succeeds Dr. William O. Barnett of Jackson.

Seven general officers meet with the Board but without the right to vote. They are the president, president-elect, secretary-treasurer, speaker of the House of Delegates, vice speaker, and AMA delegates.

Scientific Assembly Begins Work for '72

The 1972 Annual Session is set for May 8-11, with headquarters at the Sheraton-Biloxi. The Scientific Assembly has already begun planning for the 104th.

Acting by separate sections during the recent 103rd Annual Session, the seven components of the Scientific Assembly named new chairmen, and two sections elected new secretaries.

Under the By-Laws, a section chairman serves a term of only one year, but section secretaries are elected for three years. Each office carries an automatic seat and vote in the House of Delegates to assure proper representation of each scientific section.

Secretaries of the seven sections are on staggered terms so that annual elections are for two, two, and three in any three-year period.

Named to head the Section on EENT is Dr. Myron W. Lockey of Jackson. Dr. J. Kinabrew Williams, Jr., of Pascagoula enters the first year of his second term as section secretary.

Heading the Section on General Practice is Dr. Eugene F. Webb of Itta Bena. Beginning a term as section secretary is Dr. W. Boyce White of Laurel.

The internists chose Dr. David M. Owen of Hattiesburg as chairman of the Section on Medicine. Dr. S. H. McDonnieal, Jr., of Jackson continues as secretary.

Dr. William R. Raulston of Hattiesburg heads the Section on Obstetrics and Gynecology. Serv-

ing his third year as secretary is Dr. Warren C. Plauche of Biloxi.

Dr. Louis C. Lehmann of Natchez is the new chairman of the Section on Pediatrics. In his second year as section secretary is Dr. John R. Jackson of Hattiesburg.

Dr. James C. Totten, Jr., of Pascagoula will chair the Section on Preventive Medicine. Dr. Frank M. Wiygul, Jr., of Jackson will continue as section secretary.

New chairman of the Section on Surgery is Dr. W. Lamar Weems of Jackson. Dr. Benton M. Hilbun of Tupelo will serve his second of the three-year term as section secretary.

Dr. Raymond S. Martin, Jr., of Jackson, association secretary-treasurer, is constitutional chairman of the Council on Scientific Assembly.

Dr. Martin said, "The Council will be meeting this summer to review preliminary plans for the 104th Annual Session and to begin actively working on the program."

He said that the exhibit prospectus for technical exhibitors will be released this fall. Specialty societies are invited to submit plans for concurrent meetings and requests for assignment of rooms, including those for meal occasions, he added.

The president, Dr. Arthur E. Brown of Columbus, and the president-elect, Dr. C. R. Jenkins of Laurel, are *ex officio* members of the Council on Scientific Assembly under the By-Laws.

Specialty Societies Hold Concurrent Meetings

A total of 12 specialty societies met concurrently with the association during the four-day 103rd Annual Session at the Sheraton-Biloxi. Scientific sessions and social occasions drew members of almost every specialty.

Pathologists from throughout the state attended the May 2 and 3 meetings of the Mississippi Association of Pathologists. Dr. W. D. Atchison of Gulfport was named president-elect; Dr. T. S. Rodda of Clarksdale, president; Dr. Roland F. Samson of Jackson, secretary; and Dr. Catherine G. Goetz of Jackson, treasurer. Immediate past president is Dr. Carl G. Evers of Jackson.

Mississippi radiologists met Sunday, May 2, for a scientific session on vascular radiology. Dr. James B. Barlow of Jackson is president. New officers will be elected at the fall meeting.

The Mississippi Urological Society met May 3 at the Sheraton-Biloxi. New officers elected by the urologists are Dr. Charles D. Scruggs of Jackson, president; Dr. W. H. Merrell, Jr., of Jackson, secretary-treasurer; and Dr. M. E. Hinman of Vicksburg, president-elect. Outgoing president is Dr. W. J. Slaughter of Meridian.

The Mississippi chapter of the American College of Surgeons convened on May 4 for a scientific session followed by a business meeting and luncheon. New officers are Drs. W. C. Shands, president; Raymond S. Martin, Jr., president-elect; and Albert L. Meena, secretary-treasurer, all of Jackson.

Following adjournment of the section on May 4, the Mississippi Ob-Gyn Society conducted a luncheon. New officers are president, Dr. Charles M. Head of Jackson; president-elect, Dr. Walter L. Bourland of Tupelo; vice-president, Dr. George Ball of Jackson; and secretary-treasurer, Dr. Calvin T. Hull of Jackson.

A luncheon meeting on May 5 highlighted the meeting of the Mississippi Society of Internal Medicine. Dr. G. Spencer Barnes of Columbus was inaugurated president of the society. New officers elected by the internists are Dr. John R. Shell of Vicksburg, president-elect, and Dr. S. H. McDonnieal, Jr., of Jackson, secretary.

The Flying Physicians Association held a luncheon on Wednesday, May 5. Dr. Jack A. Stokes of Pontotoc was elected president.

Family physicians met at a Mississippi Academy of General Practice luncheon occasion on May 5. Dr. William H. Parker of Heidelberg is president and president-elect Dr. James O. Stephens of Magee will take office at the Academy's June 24-26 meeting.

The Mississippi Eye, Ear, Nose and Throat Association conducted a luncheon and business meeting on May 6. New officers are president, Dr. J. K. Williams, Jr., of Pascagoula; vice president, Dr. John E. Green of Hattiesburg; secretary-treasurer, Dr. L. B. McCarty, Jr., of Jackson; and councilors, Dr. J. L. Pettis, Jr., of Tupelo and Dr. Patrick L. Pierce of Gulfport.

Other specialty groups meeting during the week were the Mississippi Society of Anesthesiologists and the Mississippi Orthopaedic Society.

Following the MSMA 103rd Annual Session, the Louisiana-Mississippi Ophthalmological and Otolaryngological Society convened at the Sheraton-Biloxi for a three-day meeting, May 6-8. Dr. Paul L. Marks of Baton Rouge became president. Immediate past president is Dr. C. Hal Cleveland of Gulfport and secretary-treasurer is Dr. Arthur V. Hays of Gulfport.

Dr. Mitchell Receives Blood Bank Award

Dr. Charles B. Mitchell, pathologist at Rush Foundation Hospital and medical director for Blood Services of Mississippi received a special commendation during a conference on blood banking in Scottsdale, Arizona. The award, for outstanding community service, was in recognition of Dr. Mitchell's tenure as medical director of Blood Services' facility in Meridian for a total of 16 years.

In paying tribute to Dr. Mitchell and to the 23 other physicians attending the annual meeting, Blood Services' president, W. Quinn Jordan, expressed appreciation for their contributions to medical care in their respective communities.

"Blood banking is a public trust; the donor who gives blood and the patient who receives blood depend upon the medical and technical people in the blood bank to do their jobs thoroughly and well. As medical directors of community blood banks, each one of you devotes a part of your work day to the responsibility of supervising the required medical-technical procedures. Collectively, you have made it possible for patients in the 850 hospitals served by Blood Services' facilities to receive a quarter of a million pints of blood each year. For your willingness to accept this responsibility, we are eternally grateful."

The annual meeting of the medical directors of the Blood Services' facilities, conducted by medical director Peter V. Van Schoonhoven, provides a unique forum for the physicians, who are principally pathologists, to discuss the latest developments in blood bank techniques and patient care.

Following an intensive cross-country training program which covered the United States from Reno, Nevada to Meridian, Mississippi; and from Harlingen, Texas to Minot, North Dakota; Dr. Van Schoonhoven announced that as of March 19, 1971, all Blood Services' facilities were screening all blood donors for Hepatitis Associated Antigen:

"About 1 to 10 persons in a thousand will be found to react positively to the test (there is a geographic difference in the occurrence of the disease), and on the basis of preliminary cost projections of slightly more than a dollar for each test, it will cost the blood bank, on the average, several hundred dollars to eliminate one potential virus carrier from its panel of blood donors.

"We do have an additional measure which we have relied upon for many years, and that is a Disqualified Donor Directory. Reasons for disqualification are varied, but our principal effort is to exclude any individual with a history of viral hepatitis, involvement in a case of posttransfusion viral hepatitis, close exposure to a person known to have viral hepatitis, and now those whose blood reacts positively to the Hepatitis Associated Antigen test. Drug addicts are, of course, medically unacceptable, as are individuals with malaria, syphilis, or other physical conditions which make, or could make, giving blood hazardous for themselves or for the patient who might receive the blood."



Meridian pathologist, Dr. Charles B. Mitchell (right), receives special commendation for outstanding community service from W. Quinn Jordan, president of Blood Services in Scottsdale, Arizona. The award was in recognition of Dr. Mitchell's tenure as medical director of Blood Services' facility in Meridian for a total of 16 years.

Blood Services of Mississippi was established in 1955 under the sponsorship of the Lauderdale County Medical Society and is directed by Frank Holcomb. Blood Services, the parent organization, is the nation's largest not-for-profit, medically sponsored network of blood banks.

Northeast Miss. Gets Screening Program

Northeast Mississippi residents are now being offered the latest in health services since the institution of a multiphasic screening program in Tishomingo County.

Known as the Northeast Mississippi Mobile Multiphasic Screening Unit, it is comprised of a mobile home trailer specially designed and equipped for various health tests, along with a mobile health clinic from the State Board of Health.

The screening program has been made available through a federal grant, funded for three years, through the University of Tennessee Regional Medical Center. Counties included in the territorial range are Tishomingo, Prentiss, Alcorn, Tippah, and Benton.

The health units will be in each of the counties sometime during the three-year period and dates will be announced in advance so that the people can make appointments.

The program was begun in 1970 in Tishomingo County with Dr. Harry Cosby, Jr., of Iuka as project director. Since this time, 4,600 persons have been screened including schools and employees of factories.

Time required for the health examination is approximately 30 minutes with a report of results being received in some four to six weeks.

Tests offered include a chest x-ray, tuberculin skin test, pulmonary function for vital capacity of lungs, height and weight measurements, blood pressure, visual acuity, a glaucoma check, hearing, electrocardiogram, computer PhonoCardioScan, urinalysis, survey-12 blood chemistry profile, a complete blood count, pap smear and breast examination.

The unique service is available to anyone in the five-county area without charge and is fully supported by practicing physicians and medical teams. The test results are sent to the family physician.

There is no doctor on the health unit. It is operated by three registered nurses and three American Medical Association technicians along with four clerical employees.

The screening program is sponsored by the Memphis Regional Medical Program, Tishomingo County Hospital, Prentiss County Hospital, Mississippi State Board of Health, and Tennessee Valley Authority in cooperation with local Yellow Creek and Bear Creek Watershed Authorities.



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N. C. Clinicians Report on Abortion Agents

The prostaglandins PGE_2 and PGF_{2a} are both effective agents to induce abortion, but differ significantly in dosage levels and side effects, investigators at the University of North Carolina School of Medicine have reported.

Their study, reported at a meeting of the American College of Obstetricians and Gynecologists, in large part confirmed findings reported by Swedish and English researchers. Investigators outside of the USA have used the two experimental compounds to induce abortion in more than 400 women. A number of clinical trials are currently under way in the U. S. under grants from The Upjohn Company, Kalamazoo, Mich.

Dr. W. E. Brenner and associates of the North Carolina group told the meeting that the two prostaglandins were effective in inducing abortion in nine of the ten patients on whom they were tried. But of the two prostaglandins, "PGE_2 had a higher successful rate of abortion in a shorter period of time and accomplished abortifacient uterine activity in a higher percentage of patients at lower relative doses than did PGF_{2a}."

In their random, double blind study, each of the prostaglandins was administered by intravenous infusion to five women in the 7th to 20th weeks of pregnancy who sought abortions for psychiatric reasons.

Patients received from 2.5 to 20 micrograms per minute of PGE_2, and from 25 to 200 micrograms per minute of PGF_{2a} in progressively increasing doses for 12 hours.

Since this was both an efficacy and a tolerance study, dosage was increased stepwise in each instance until the highest dosage range was achieved or significant side effects were noted. The frequency and severity of complications (side effects) depended upon which drug was used and the dosage employed. Nausea, vomiting, and a temperature of more than 100°F. were more commonly observed PGF_{2a} infusion, while a temporary inflammation of the infused vein was often noted with PGE_2. In no instance were the side effects severe enough to require shortening of the planned 12 hour infusion.

Although a statistically significant difference in efficacy could not be demonstrated in these 10 patients, PGE_2 appeared more effective. All five of the patients aborted with PGE_2 while only four of the five aborted with PGF_{2a}. Twice as many patients aborted during the first 12 hours of infusion with PGE_2 compared with PGF_{2a}, and the mean abortion time was about five hours less with PGE_2 than for PGF_{2a}.

Since this preliminary study, 16 patients have been infused with PGF_{2a}. Fifteen patients aborted and the frequency of side effects is similar to that of the original series.

Dr. Brenner noted that the use of prostaglandins is still experimental, and that commercial prostaglandins are not available.

Interviewing Computer Is Tested at UAB

A computer which interviews patients is being tested at the University of Alabama in Birmingham (UAB).

The new automated medical interviewing system is designed to assist physicians in taking medical histories of patients, thus freeing doctors to spend more time with individual cases.

Conceived by Drs. Warner and Charles Slack, the computerized demonstration was made possible by UAB and Harvard Medical School's Beth Israel Hospital.

The system is simplicity itself: before he sees the physician, the patient communicates directly with the computer, entering his own medical history by answering questions spelled out to him on a small television screen. The patient responds to questions by pressing answer keys on a typewriter keyboard.

The advantages are numerous. Unlike humans, the computer never forgets to ask or record a question. It has infinitely more patience. It prints out a completely legible detailed record compared to the physician's often hurried handwriting.

Not only does the computer take the medical history and store it for future reference in emergency situations, it prints out a complete copy for the physician to read prior to his personal interview with the patient.

From the patient's point of view, automated interviewing is often just plain fun—particularly when the computer exhibits humanlike qualities:

Computer halfway through the interview: "You have done well. Are you getting tired?" Patient: "Yes." Computer: "Well, are you willing to continue for a while longer?" Patient: "No." Computer: "Please." Patient: "No." Computer: "Okay, take a break."

Additionally, patients tested thus far say they feel more comfortable giving intimate information to a computer than to a physician. They seem to like the fact that the computer routinely asks the same questions of everyone.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 20-24, 1971, Atlantic City, Clinical Convention, Nov. 28-Dec. 1, 1971, New Orleans. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

AMA Congress on Occupational Health, 31st Annual Congress, Aug. 29-30, 1971, Grand Teton National Park, Wyoming. Louis R. Skiera, Assistant Director, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

STATE AND LOCAL

Mississippi State Medical Association, 104th Annual Session, May 8-11, 1972, Biloxi. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Mississippi Academy of General Practice, Annual Assembly, June 24-26, 1971; Biloxi. Miss Louise Lacey, Executive Secretary, P.O. Box 3112, Jackson 39207.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Robert P. Henderson, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Second Wednesday, April and First Wednesday, November, 2:00 p.m., Clarksdale. Glenn L. Wegener, 1967 Hospital Drive, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. James E. Booth, Eupora, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. A. Robert Dill, 1001 Main Street, Columbus, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Robert Donald, Box 1351, Pascagoula, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie Street, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday, January, April, July, and October, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.

NIMH Launches New Career Training Program

A new careers training program, designed to increase the scope and effectiveness of community mental health services, is being launched by the National Institute of Mental Health, Health Services and Mental Health Administration.

According to Dr. Bertram S. Brown, NIMH Director, the program will aid state and local efforts to recruit and train the new types of personnel needed to serve those population groups and geographic areas that have been neglected by traditional mental health services.

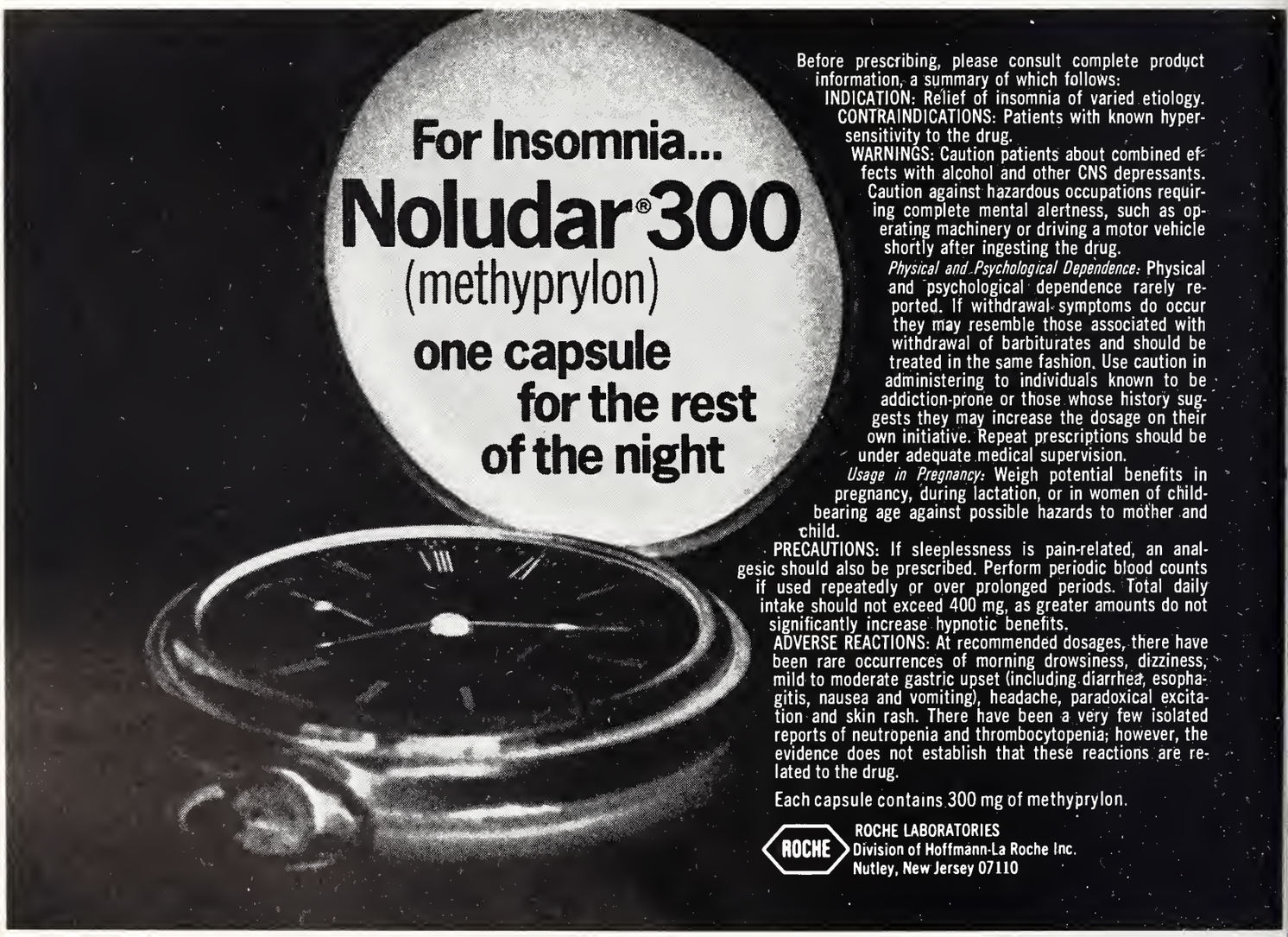
"The term 'new careerists' will be broadly defined," Dr. Brown said, "to include individuals who will be trained to do new mental health jobs, such as outreach and patient advocacy, as well as persons who will be trained for jobs previously considered to be the exclusive domain of more highly trained professionals.

"In other words," he said, "new careerists will become important members of the treatment team in a variety of community and hospital settings, particularly in areas where mental health services are now in short supply."

$1.5 million in fiscal year 1972 funds has been earmarked by the NIMH's Division of Manpower and Training Programs to support interdisciplinary training of the new careerists. Grants will be awarded on a competitive basis to training institutions, community agencies, community mental health centers, and hospitals.

Grants of up to $100,000 will be awarded for a maximum duration of three years. Stipend support can be included only when funds are not available from other sources. The initial deadline date for filing applications will be September 1, 1971. Approved programs can begin training May 1, 1972.

Further information about the training support program can be obtained from Dr. E. Fuller Torrey, acting chief, New Careers Program, Division of Manpower and Training Programs, National Institute of Mental Health, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015.



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Warnings: Safe use in pregnancy has not been established, and teratogenicity potential has not been thoroughly investigated. Sulfonamides will not eradicate or prevent sequelae to group A streptococcal infections, *i.e.*, rheumatic fever, glomerulonephritis. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; early clinical signs such as sore throat, fever, pallor, purpura or jaundice may indicate serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination are recommended frequently during sulfonamide therapy. Clinical data are insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient indi-

NEWSLETTER

July 1971

Dear Doctor:

Mississippi ranks 13th in U.S. in immunization of susceptible population against rubella, according to State Board of Health. Report says that coverage is 64 per cent in children one through 12, and among those five through nine, immunizations have been given to 90 per cent. Mississippi leads all eight southeastern states in program and is behind 12 states with smaller populations.

> Top priority is being given to immunizing preschool group, and order has been issued to make rubella shot mandatory. Implementation of order, however, jointly issued Board of Health and Department of Education is at discretion of local school boards in fixing admission health criteria.

Institutional advertising in major media has been instituted by AMA and California Medical Association in separate programs. AMA plans $750,000 annual effort, making use of mass circulation magazines. CMA launched similar program in spring with full page ad in Newsweek. AMA program is largely informational with some low-pressure sell on its position in national health insurance proposals.

Mississippi Medicaid program is laying out most money for prescription drugs with physicians' payments running fourth. Of all funds now being spent, drugs are running 24 per cent, nursing homes 23 per cent, hospital bills 18 per cent, and M.D. fees, 15 per cent. Program budget is $41 million for year which includes administrative costs and Part B Medicare buy-in for over-65 Medicaid recipients.

Nixon administration, AMA, and medical schools will win fight on the $100 million "conquest of cancer" program in final congressional act. Super research project will be within National Institutes of Health with a director reporting directly to President Nixon. Pushed aside will be bill by Sen. Edward Kennedy (D.,Mass.) who would have set up separate agency apart from total health and medical research of NIH.

Action by New Mexico Medical Society may result in mandatory continuing education as precondition to practice in state. Legislature has empowered State Board of Medical Examiners to require proof of minimum prescribed postgraduate training for annual re-registration of license. Measure was introduced and passed at request of state medical society which has shown get-tough attitude on M.D. learning.

Sincerely,

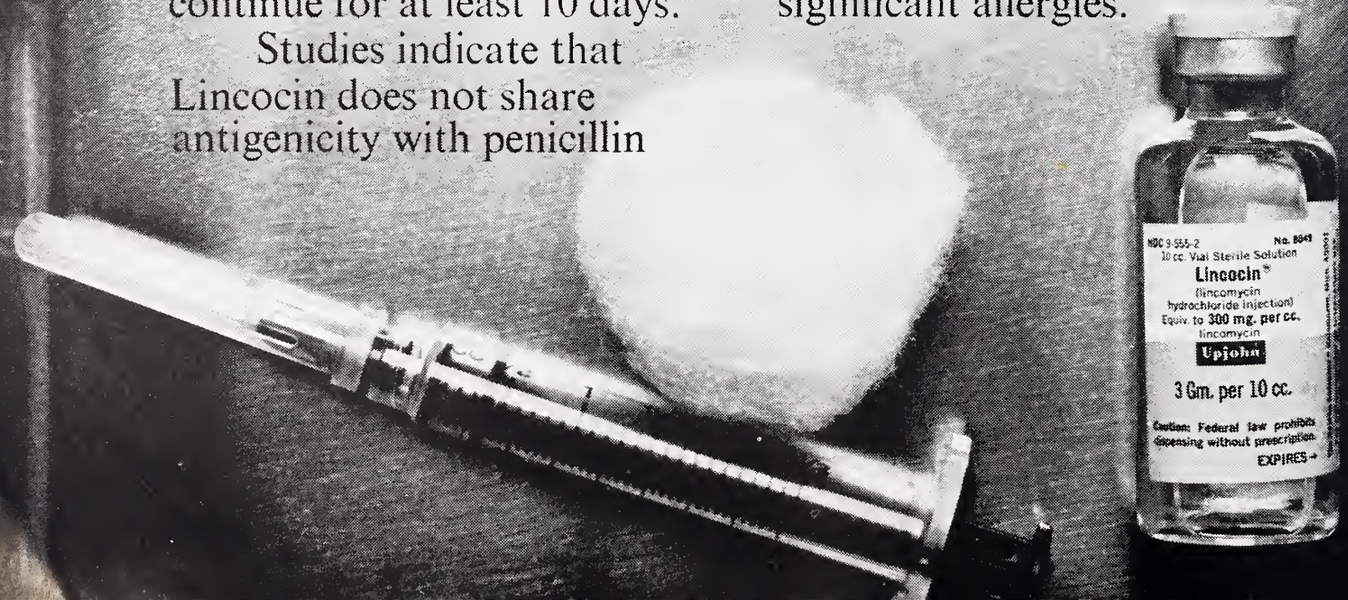
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Executive Secretary

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DATELINE

Coast Has Abortion Referral Agency

Biloxi - Mississippi M.D.'s have received letter announcement of abortion referral service based on Gulf Coast which funnels patients to New York where commercial referral agencies have proliferated. Foes of commercial abortion business got encouragement when state supreme court ruled one agency illegal, both for fee splitting and wrongfully practicing medicine. Many M.D.'s are outraged by commercialism, and liberal N.Y. law is under attack by legislature and profession.

Shield Is Urged to Improve Coverage

San Francisco - Retiring Blue Shield President John W. Castellucci told recent NABSP convention that Blue Shield must give the public more for their money. Calling for improved performance by member plans, he stressed development of usual, customary, and reasonable fees for physicians. The 71 U.S. plans cover 65 million Americans, and UCR and utilization review are now Blue Shield plan membership standards. Most Blue Shield plans have developed UCR coverage.

Peer Review Bills Are Before Congress

Washington - AMA's peer review (PRO) bill is in the congressional hopper and would place programs under state medical associations. Measure applies to Medicare and Medicaid. New Social Security bill, H.R. 1, also has peer review provisions but takes a variety of approaches, including administration by state medical associations. Under latter, however, review programs may be instituted by HEW when medical association chooses to take no action. MSMA is instituting association program.

MIC Will Direct Developmental Act

Jackson - Gov. John Bell Williams has named the Interagency Commission on Mental Illness and Retardation as body to administer Developmental Disabilities Services Act of 1970. MIC will coordinate formulation of plan through interorganization council to aid persons suffering developmental disabilities. Law defines beneficiaries as those with CP, epilepsy, retardation, or neurological conditions such that normal development is impaired.

CHAMPUS Extends Dental Care

Denver - Maternity patients under CHAMPUS may qualify for dental care, a service not ordinarily available. CHAMPUS officials announced that where obstetrician managing pregnancy says dental care is vital to health of patient and unborn child, service may be provided. Law excludes most dental services, but recent announcement permits care when necessary to health in pregnancy. Additional bonus is that such care will be considered inpatient with less cost to patient.

EEG Aids in Schizophrenia Study

A promising tool in the study of schizophrenia is featured in the new issue of the *Schizophrenia Bulletin,* a publication of HEW's National Institute of Mental Health, Health Services and Mental Health Administration.

Known by its scientific name as averaged evoked response, the sophisticated technique allows researchers to study the physical correlates to certain aspects of schizophrenic behavior by studying electroencephalogram (EEG) readings.

Previously, study of schizophrenics' central nervous system function has been difficult because such research involves either autopsy or implanting electrodes in a patient's brain, a hazardous surgical procedure.

The development of computer technology concurrent with the development of the averaged evoked response technique has made feasible large-scale patient testing.

The experimental quarterly journal is published by the NIMH's Center for Studies of Schizophrenia and the National Clearinghouse for Mental Health Information. Its purpose is to increase the exchange of information on schizophrenia among professionals concerned with this problem. More persons are hospitalized for schizophrenia than for any other single psychiatric disorder.

In addition to timely reports of research, the Bulletin regularly contains a bibliography and abstracts from other journals.

Among the principal contributors to the newly released third issue are Dr. Monte Buchsbaum, NIMH, and Dr. Reese T. Jones, University of California, San Francisco Medical Center and the Langley Porter Neuropsychiatric Institute.

Dr. Buchsbaum explains the basic technology involved in averaged evoked response studies, and Dr. Jones reviews findings.

The issue's cover carries a dramatic illustration by a former mental patient, Mary Barnes of London. Each bulletin cover features the artwork of a victim of the affliction.

A complimentary copy of the *Schizophrenia Bulletin* may be obtained by writing to the Publications Management Branch, National Institute of Mental Health, Health Services and Mental Health Administration, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015.

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Psychotropic Agents Document Published

The safety and effectiveness of medications for the treatment of mental illness and their scientific evaluation are discussed in a new publication announced by HEW's National Institute of Mental Health, Health Services and Mental Health Administration.

"Principles and Problems in Establishing the Efficacy of Psychotropic Agents," published jointly by NIMH and the American College of Neuropsychopharmacology, documents the clinical assessment of psychotropic drugs. The volume is designed to reach scientists and others engaged in the development of psychotropic drugs.

The book, whose contributors are the country's leading authorities on the use and development of drugs for mental illness, was prepared under the direction of the American College of Neuropsychopharmacology, through its Government-Industry Liaison Committee. A special committee composed of investigators in psychopharmacology from universities, government, and industry as well as others engaged in the field formulated the document.

As noted by the Editors in the Preface, ". . . although techniques for the clinical evaluation of psychotropic agents had advanced considerably in the last decade through the increasing sophistication of methodology and improved instruments for scoring patient response to treatment, no criteria for the judgment of a drug's efficacy had been made explicit. This lack of criteria made the FDA's task especially burdensome and at the same time served as a source of frustration to the pharmaceutical industry in its planning of clinical research to provide data for support of an application to market a new product."

The Editors further state that ". . . no hard and fast guidelines are intended; rather we view this as a living document representing the state of the art in 1970 and, as such, anticipate it will undergo change and require revision. A start has been made and we hope this publication will stimulate additional discussion and consideration of the problems of defining and establishing the efficacy of psychotropic agents."

Editors are Drs. Jerome Levine and Lorraine Bouthilet, National Institute of Mental Health, and Dr. Burtrum C. Schiele, University of Minnesota Hospitals, chairman of the Steering Committee.

"Principles and Problems in Establishing the Efficacy of Psychotropic Agents," a 392-page hardbound book, PHS Publication No. 2138, may be purchased at $3.25 from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

Brief Summary of Prescribing Information— 9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
July 1971, Vol. XII, No. 7

ORIGINAL PAPERS

Present Status of Myocardial Revascularization

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Surgery for myocardial ischemia has been approached from practically every aspect. The authors discuss various methods, the majority of which have been abandoned. Their experience with 150 operations proves that coronary reconstruction is based on sound principle, and with proper selection and execution of the operative procedure, a definitive means of myocardial revascularization exists.

THE HISTORY OF SURGERY for coronary artery disease has been that of disagreement between the surgeon and his medical colleague. Associated with this disagreement have been periods of enthusiasm and disappointment for a particular operative procedure, which have led both surgeon and internist to confusion.

Efforts to improve coronary circulation by surgical means began more than 50 years ago, and since then many operative procedures have been suggested for the relief of angina pectoris. Although many of these procedures received extensive experimental evaluation and claimed frequent clinical success, their value remained questionable. This is understandable when one considers the unfounded physiologic approach upon which some operations were based and the obvious hoax others portrayed. In general, until recently surgery for coronary artery disease did not enjoy an envious position. In fact, many physicians closed their minds to the possibility that surgery had a place in the treatment of myocardial ischemia. It is probably wise that the medical profession did not rush to accept the numerous surgical procedures, for many would have undergone ill-advised operations in vain.

Today, operations for revascularizing the heart have been accepted by both surgeon and his medical colleague. However, it was improved diagnosis and not surgical technique that established surgery for coronary artery disease. The introduction of selective coronary arteriography by Sones[1] in 1958 cleared the way for surgical revascularization. This modality demonstrates the morphology of the coronary arteries and thereby defines the needs of the individual patients and determines the selection of operative procedure.

In no other place in surgery have so many operations been proposed and championed by so

Presented before the Section on Surgery, 102nd Annual Session, May 12, 1970, at Biloxi.
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many different surgeons. The many operations proposed to relieve angina pectoris or to improve myocardial blood flow vary greatly as to the means in which they attain the end result. These operations can be divided into three general categories: 1) physiologic alterations; 2) coronary augmentation; and 3) coronary reconstruction. (See Table 1)

In the first group—that is, those procedures which produce an alteration in the physiology of the heart or physiologic demands upon the heart —three different operations have been proposed: 1) interruption of the sympathetic nerve supply to the heart; 2) thyroid ablation; and 3) carotid sinus nerve stimulation. The first surgical approach in the treatment of coronary artery disease was through the sympathetic nervous system. The original investigators were of the opinion that interruption of the sympathetic nerve supply to the heart would actually increase blood flow to the heart. Now it is generally conceded that division of the sensory fibers to the heart results only in relief of pain of angina pectoris.

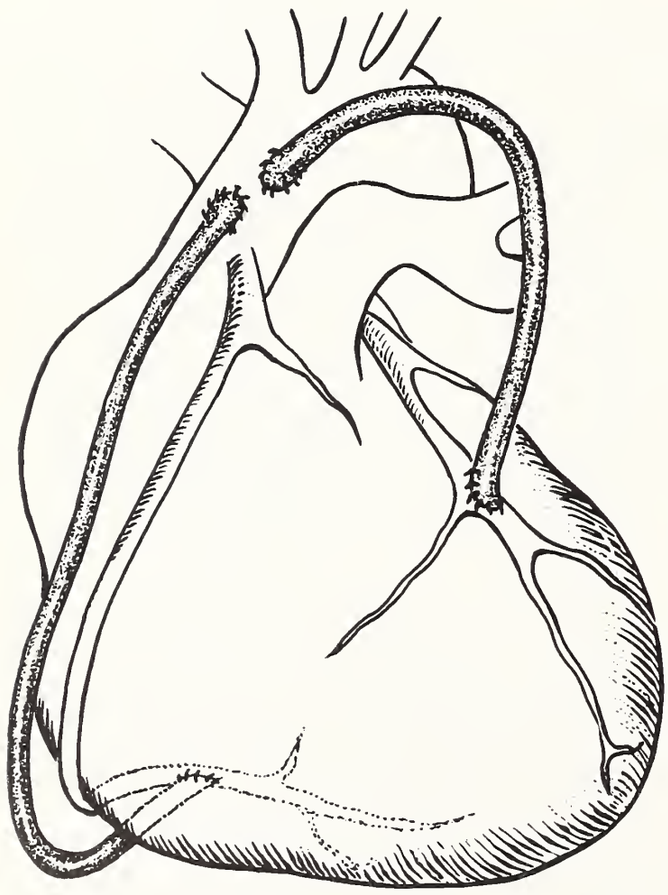


Figure 1. This drawing illustrates bilateral aorto-coronary artery bypass typical of the operations performed for multiple coronary artery disease. One bypass is to the right coronary artery in the diaphragmatic surface and the other is to the anterior descending branch of the left coronary artery.

The neurosurgical approach produced an overwhelming impact and, if for no other reason, this approach produced a stimulation in research and advancement in this particular field. Francois-Franck,[2] a professor of physiology in France, suggested that sympathectomy be performed to relieve the pain of angina pectoris in 1899. The first cervical thoracic sympathectomy for treatment of angina pectoris was performed by Jonnesco[3] in 1916. This was a rather long and radical operation for that day and time, and it was modified to simplicity by others who emphasized that only sensory fibers should be resected, preserving the motor sympathetic pathways. Some surgeons[4] reported series in which simple resection of the superior cervical ganglion, or merely division of the main cardiac branch of this ganglion, produced relief of symptoms of angina. Other surgeons[5] felt that resection of the first four thoracic ganglions was necessary to consistently interrupt the anatomic pathways associated with cardiac pain.

Subtotal thyroidectomy was first advocated by Boas and Shapiro[6] in 1925 and total thyroid ablation was suggested by Blumgart, Levine and Berlin[7] in 1933. These investigators felt that reduction of thyroid function would be helpful in an effort to decrease the metabolic requirements of an ischemic heart and thereby allow it to function more efficiently in the presence of its reduced vascular supply. Within 10 years this operation was abandoned because the results were not considered sufficient to justify the hazards of tetany, recurrent laryngeal nerve injury, a significant mortality rate, and the establishment of severe myxedema.

Recently, Braunwald,[8] following the work of Schwartz et al[9] advocated electrical stimulation of the carotid sinus for control of angina. The hypothesis is that stimulation of the carotid sinuses abolishes angina by lowering three important factors that influence the heart's energy needs—ventricular pressure, heart rate, and myocardial contractibility. Only a limited number of patients have been selected for this method of treatment and it may well be that some of these patients may have been offered another alternative, had coronary angiography been performed. Further clinical evaluation of this form of therapy is needed to determine its efficacy. The objective is to control incapacitating angina pectoris. It is unlikely that longevity will be increased by this treatment.

The group of operations designed to augment existing coronary blood supply is numerous.

These operations have been the subject of much debate and have had strong protagonists and antagonists. Those operations designed to produce vascular adhesions between the heart and other structures, plus the operation in which the internal mammary arteries are ligated, attempt to bring a new source of blood to the surface of the heart. The suffix, -pexy, refers to fixation. The first operation which produced adhesions between the heart and another structure was cardiomyopexy, which was performed by Beck[10] in 1935. This was the first operation upon a heart in an attempt to bring blood to an ischemic heart. The pectoralis major muscle was sutured to the abraded epicardial surface of the heart. Since that time, practically every structure in the body has been used either experimentally or clinically to effect this end. Such operations include cardiopericardiopexy, cardio-omentopexy, cardiopneumopexy, cardiojejunopexy, cardiogastropexy, and cardiolienopexy. These operations have lost most of their followers, although Vineberg[11] still contends cardio-omentopexy is a useful procedure in the total revascularization of the heart.

TABLE 1
OPERATIONS FOR MYOCARDIAL ISCHEMIA

PHYSIOLOGIC ALTERATIONS
Interruption nerve pathways
Thyroid ablation
Carotid sinus nerve stimulation
CORONARY AUGMENTATION
Production vascular adhesions
Internal mammary ligation
Venous stasis or reversal coronary circulation
Intramyocardial implantation of artery
Acupuncture
CORONARY RECONSTRUCTION
Endarterectomy
Substitution graft
By-pass graft

In 1939, at the suggestion of Fieschi, Zoja and Cesa-Bianchi[12] ligated both internal mammary arteries to increase blood flow to the heart via proximal intercostal collateral vessels. This operation was championed and supported by a very prominent young American surgeon, Dr. William Glover.[13] Dr. Glover did experimental work in which he proved to his satisfaction that the operation was effective. He recorded that the pressure in this artery increased and that collateral vessels did develop proximal to the site of ligation of the internal mammary artery. Many cardiac surgeons[14] of that era repeated Glover's experiment and none of them could reproduce his findings. Unfortunately, before this issue could be settled, Dr. Glover died at an early age of carcinoma of the rectum. It is unfortunate that a man who made so many contributions in the field of cardiovascular surgery and who would have been the first to admit the ineffectiveness of this operation —particularly after sham operations with similar skin incisions produced the same clinical results— died before the ineffectiveness of this procedure was proved.

The operations which produced coronary venous stasis or reversal of coronary circulation were advocated by Dr. Claude Beck[15] and referred to as the Beck I and Beck II operations. Beck I operation consisted of cardiopericardiopexy and a stenosis of the great cardiac vein. The Beck II operation consisted of stenosis of the coronary sinus and reversal of flow through the sinus with systemic blood from a vascular graft taken from the descending thoracic aorta. This latter procedure had a very high mortality rate, as one might expect, since these operations were performed before the advent of extracorporeal circulation. Needless to say, very few surgeons, including Dr. Beck himself, did many of these operations because of the high associated mortality.

The intra-myocardial insertion of an artery or a graft has probably had the greatest clinical application to date. Practically every systemic artery and various autogenous and prosthetic materials have been used to shunt blood from the systemic circuit into the myocardium. In 1945, Vineberg[16] hypothesized that implantation of an extracoronary source of blood within the myocardium would bring oxygenated blood to an ischemic area. He believed that the myocardial sinusoids would initially absorb the flow of blood and eventually endothelial connections would form between the implanted vessel and the myocardial arterioles. He advocated the internal mammary artery as the preferred vessel to bring this extracoronary source of blood. There have been numerous modifications of his operation and many thousands of these operations have been performed. There is no doubt that anastomotic channels communicate between the implanted internal mammary artery and the coronary vessels. Although most of the enthusiasm for this procedure has recently disappeared with the advent of newer operations, there are still strong proponents of the operation as a primary or secondary procedure. There have been conflicting findings as to the clinical and physiological efficacy of the internal mammary-myocardial implantation, and much study is still in progress to determine if, where and when the procedure should be employed.

The latest means of augmenting coronary circulation is acupuncture, as advocated by Dr. Sen.[17] This procedure is based on the fact that the heart of a reptile consists of central channels radiating from the myocardial cavity supplying nearly the entire thickness of the heart, except for a thin external coat which receives its blood supply from the external coronary arteries. This is the opposite of the mammalian heart. By applying acupuncture to the human heart, surgeons have attempted to bring new blood to the ischemic or infarcted areas. This blood is brought to these areas from the blood in the ventricular cavities. Very few have accepted this thesis, and there has been only sparse clinical application.

CORONARY RECONSTRUCTION

Direct revascularization of the heart by coronary reconstruction has excited both surgeon and internist. Correction of ischemia by immediate revascularization implies sound principle. Reconstruction has been accomplished by coronary endarterectomy, with or without patch graft; substitution of an occluded segment of coronary artery by graft; or by-passing an obstructed area with an autogenous vein graft. The first coronary endarterectomy was performed by Bailey[18] in 1958. This was a blind endarterectomy in which he shelled out a plaque in a branch of a coronary artery.

Because of the high mortality in the early years of coronary reconstruction few operations were performed until recently. Recent refinement in techniques and a better understanding of pathophysiology of coronary artery disease has enabled the cardiac surgeon to progressively decrease the risk of immediate coronary reconstruction to an acceptable level. An increasing number of such operations are being performed. Early experience in the selection of patients for myocardial revascularization revealed that only 5 per cent of patients with coronary artery disease were candidates for direct reconstruction; however, today this figure approaches 95 per cent.

In the past three years, a voluminous amount of work has been done. Techniques have been revised and improved to the point where today some surgeons believe that almost every ischemic heart can be improved by direct coronary reconstruction. Although endarterectomy was the first method, it has fallen into disrepute because of the high recurrence of obstruction in the endarterectomized segment. Endarterectomy does not change the natural course of the disease and only sets up a focus for accentuation of the natural occlusive process in those so prone. Occasionally, obstruction of a coronary artery is localized and so situated that excision of the occluded segment and replacement by an autogenous vein graft is easily performed. Today the most common procedure is bypass of the obstructed segment with an autogenous vein from the ascending aorta to a patent coronary artery distal to the obstruction. (See Figure 1) It is amazing that we cardiovascular surgeons were so long in adopting this latter procedure when, in reality, we have been bypassing blocked arteries everywhere in the body except for the heart for many years. The heart is the ideal organ in which to bypass, for the bypass graft does not have to be long, has continuous motion and rapid run-off, all of which enhance long-term patency. The only detriment in coronary bypass is the size of the vessel, but refinement in techniques has allowed the cardiovascular surgeon to progressively reconstruct smaller vessels.

From December, 1964, through December, 1969, 150 operations have been performed at the Ochsner Clinic for myocardial revascularization. In the first 100 operations, 95 were indirect methods of revascularization and in only five were the coronary arteries reconstructed. In contrast, of the last 50 operations, direct coronary reconstruction was performed with or without a supplementary indirect procedure in all except three patients. Table 2 shows the type and number of operations performed. In general, the operations are listed as they chronologically appeared in our preferred surgical approach to the problem of

TABLE 2

MYOCARDIAL REVASCULARIZATION

Procedure	*No. of Patients*
Indirect:	
Internal Mammary Implant	33
Internal Mammary Implant and Omental Graft	11
Internal Mammary and Saphenous Vein Implant	4
Bilateral Internal Mammary Implant	50
Direct:	
Coronary Endarterectomy	4
Coronary Interposition Graft	3
Aorto-Coronary Artery By-Pass	
Right	18
Right with Internal Mammary Implant	8
Left	9
Multiple	10
Total	150

myocardial ischemia. Originally, the only patients selected for myocardial revascularization were those in which the disease was mainly limited to the anterior descending branch of the left coronary artery. With time, we extended our indications to more diffuse disease in an attempt to totally revascularize the heart. To accomplish total revascularization, initially, the internal mammary-myocardial implantation was combined with a free omental graft after epicardiectomy. The operation has been difficult to assess since we have

TABLE 3

POSTOPERATIVE EVALUATION OF 53 PATIENTS WITH INTERNAL MAMMARY-MYOCARDIAL IMPLANTS

	Patients
SINGLE IMPLANT	24
Patent	23
Functioning	20
DOUBLE IMPLANT	28
Both patent	8
Both functioning	3
One functioning	2
One patent	16
One functioning	12
Both occluded	4

no objective means to determine the effectiveness of an omental graft. This, plus the fact that the majority of these patients underwent stormy postoperative periods as the result of a chemical mediastinitis from the free omental graft, directed us to abandon the operation. A few patients underwent an attempt at total revascularization with a single internal mammary implant anteriorly and an autogenous vein grafted from the descending thoracic implanted to the posterior myocardium. Postoperative angiographic studies failed to show patency of any of the posteriorly positioned saphenous vein implants. The most commonly employed indirect operation was the use of two internal mammary arteries implanted both into the anterior and posterior surface of the heart.

Postoperative angiographic evaluation has been performed on 53 patients with internal mammary-myocardial implants. (See Table 3) The study was performed in each patient at least one year after operation. Of the 24 single implants into the anterior aspect of the left ventricle, 23 remained patent, and 20 of these appeared to be functioning—that is, showed angiographic filling of the coronary arteries. In contrast, of the 28 patients who had double implantation, both implants appear patent in only eight patients, and only in three did both appear to be functioning. In 16 patients, only one implant was patent, and in 12 of these the vessel appeared to be functioning. In each of these 16 patients, the patent vessel was that which was implanted anteriorly. In four patients, both vessels were found to be occluded. Thus, of the 28 posterior myocardial implantations, only eight were open, and in only three (11 per cent) was the implant functioning. In contrast, of the 53 anterior myocardial implantations, 47 (89 per cent) are patent, and 37 (70 per cent) appear to be functioning.

Clinical assessment of the results parallels that which is expected by the angiographic studies. The patients with the best clinical results were those patients with open and functioning implants in the anterior aspect of the left ventricle in which there was minimal disease in the right and left circumflex coronary vessels, or, if the right and circumflex vessels were markedly diseased, there was good collateral circulation between these vessels and the anterior descending branch of the left coronary artery.

Coronary endarterectomy with use of a pericardial patch graft to enlarge the arteriotomy incision was the initial operation employed for immediate or direct revascularization. Four such operations were performed. Re-stenosis and occlusion at the endarterectomy site have been frequent. One of two patients studied postoperatively proved to have occluded the endarterectomized segment. In three patients an antogenous vein was used to substitute an occluded segment of coronary artery which was resected. Although this means of coronary reconstruction appears applicable, it has no advantage over by-pass procedures. The latter, on the other hand, does not interrupt existing channels and larger anastomoses are more easily obtained. In the past year all direct revascularization has been achieved by aorto-coronary artery by-pass utilizing an autogenous vein as the by-pass graft. The right coronary and anterior descending and circumflex branches of the left coronary artery have been reconstituted by this method. Depending on the morphology as noted angiographically, these vessels are singularly or multiply by-passed.

Postoperative angiographic visualization of aorto-coronary artery by-pass has been performed on only 12 patients. Eleven of the 12 have demonstrated open by-pass graft filling the distal coronary branches. The majority of these were performed in the relatively early postoperative period. One patient developed a stenosis at the graft-coronary artery anastomosis three months postoperatively and required reoperation for correction. It is difficult at this time to project the long-term

fate of these grafts. One hopes that they attain at least the satisfaction of arterial by-pass grafts in other areas of the body.

From the aforementioned discussion, we have concluded that the original operation proposed by Vineberg—that is, implantation of the internal mammary artery into the anterior aspect of the left ventricle—is the only indirect operation acceptable. We base this conclusion on the postoperative clinical evaluation and the angiographic studies of the implants. Therefore, we no longer can recommend an indirect operation into the posterior aspect of the heart, and yet we feel that anterior indirect revascularization is worthwhile when direct revascularization is not possible.

Unfortunately, since the acceptance of coronary reconstruction, many surgeons have abandoned the Vineberg operation. The vast majority of patients who previously underwent internal mammary-myocardial implantation for myocardial ischemia could have been candidates for coronary reconstruction. However, this does not imply that the Vineberg procedure was, or is, of no benefit. In particular circumstances, the morphology of coronary artery disease is such to prohibit coronary reconstruction, and yet the myocardium is capable of acceptance of an internal mammary implantation for indirect revascularization. Even more common is the situation where both indirect and direct methods of revascularization should be used. In the past year, many patients who previously had one or two internal mammary-myocardial implants and were initially relieved of angina have returned with recurrence of symptoms as a result of progression of the disease and have been accepted for direct reconstruction. In some of these, the implantation has been the major, and in one particular patient the only, source of coronary blood flow.

SUMMARY

Surgery for myocardial ischemia has been approached from practically every aspect. The majority of proposed operations have been abandoned; however, some remain as a result of clinical assessment. A review of our experience has enabled us to draw certain conclusions. It appears that coronary reconstruction is based on sound principle, and with proper selection and execution of the operative procedure, a definitive means of myocardial revascularization exists. Revascularization surgery should no longer be considered in its developmental stages since operative risks have progressively declined to a respectable level. This reduction is attributed to improved methods in the selection of patients, progressive refinement in anesthesia and surgical techniques, and improved postoperative management.

The internal mammary-myocardial implantation has proven to be useful as an indirect means of revascularization of the anterior aspect of the left ventricle. Attempts to use this modality to revascularize the posterior aspect of the heart have been unsuccessful in our experience. The anteriorly placed internal mammary-myocardial implant can be used as an adjunct to coronary reconstruction and rarely may be the only acceptable procedure. ★★★

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ADDENDUM

Since submission of this paper, an additional 150 patients have undergone direct myocardial revascularization. The mortality rate for the 200 patients is 5.1 per cent. In those patients who have undergone postoperative angiography, 90 per cent have shown patent aorto-coronary artery bypass grafts. Today, the most common operative procedure employed is a double aorto-coronary artery bypass with one bypass going to the anterior descending branch of the left coronary artery and the other bypass going to the posterior descending branch of the right coronary artery.

J.L.O.
June 1, 1971

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DOCTORS EXPENSIVE?

A doctor, picking up his car at a garage, was highly indignant at the size of the repair bill. "All this for a few hours' work!" he yelped. "Why, you charge more for your work than we of the medical profession do!"

"Well now," drawled the mechanic, "the way I look at it, we got it coming to us. You guys have been working on the same old model since time began, but we gotta learn a brand-new model every year."

—*Reader's Digest*

Dangers in the Local Use of Ophthalmic Corticosteroids

THOMAS W. WESSON, M.D., and
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SOME DANGERS in the use of ophthalmic corticosteroids were pointed out to Mississippi physicians in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION as far back as 1962.[1] Despite the warning literature included in the package inserts, and despite numerous articles in the ophthalmic literature,[2] we continue to see in our practice a considerable number of eye patients who either have been made worse or whose disease has actually been initiated by the improper use of a local corticosteroid.

The medical profession as a whole, without realizing the dangers involved, has been oversold on the value of a corticosteroid drop or ointment in the eye. In an attempt to alert our non-ophthalmic colleagues in the medical field, we are here presenting some typical cases.

A masterly summary of herpes simplex keratitis has been presented by Pettit.[3] The herpes simplex virus is an endemic infection which is found in 90 per cent of the adult population. The initial contact and primary infection with herpes virus occurs most frequently in childhood. Acute vesicular gingivostomatitis is the most common clinical manifestation. Other primary forms may be acute keratoconjunctivitis and acute vesicular dermatitis of lids (as reported here in Case No. 4).

Once an individual has experienced a primary herpes simplex infection, he may be subject for many years to recurrent attacks. This is particularly true of the cornea. Recent literature suggests that as far as the eye lesion (dendritic ulcers) and the peri-oral skin lesions ("cold-sore") are concerned, the cells at the site of the recurrence merely represent cells that are being bathed at intervals by secretions containing varying levels of herpes virus emanating from a chronic lacrimal or salivary gland infection.

The authors point out some dangers when corticosteroids are used locally to treat the eye. Specific conditions which need emphasis are activation of herpes simplex lesions, production of fungal ulcers, and secondary glaucoma. Case illustrations of such patients that come to the attention of ophthalmologists are presented.

On the corneal surface the virus produces a characteristic branching dendritic figure. At the onset of an attack of corneal herpes the patient has a foreign body sensation with watering and redness, often assuming that he has an ordinary conjunctivitis. If untreated, the virus is likely to spread, involving 25-50 per cent of the corneal surface. Such a cornea is shown in Figure 1. This eye went 11 days without treatment before the patient was first seen in our office.

If the virus spreads into the corneal stroma and into the uveal tract the eye may be lost from a severe uveitis (as reported here in case No. 5). Despite production of systemic antibodies, herpes simplex of the cornea is frequently a recurrent condition. Known reactivating factors include fever, sunburn, allergies, emotional stress, menstruation, steroids, upper respiratory infections and trauma. Once the corneal lesion has been activated, the addition of local steroids to the therapy causes it to spread rapidly.

From the Department of Surgery (Ophthalmology) of the North Mississippi Medical Center, Tupelo, Miss.

CASE REPORTS

Case No. 1. A 12-year-old girl developed rubella. On the day following her skin eruption the mother noted some reddening of the eyes. Ophthalmic drops containing neomycin and hydrocortisone (Neohydeltrasol) were prescribed by the family physician and were used faithfully every four hours during the day and occasionally through the night. Forty-eight hours later she was brought to our office with extreme pain, photophobia, and blepharospasm. She had to be led into the office since she could not get her eyes open. Inspection revealed approximately 25 dendritic figures on each cornea. An ointment containing idoxuridine (Stoxil) was instilled daily and the eyes were patched for three days after which the corneas remained healed.

Case No. 2. A physician awakened Sunday morning with a slightly reddened scratchy eye. Not wishing to disturb his colleagues on Sunday, he instilled in the eye a small amount of ointment containing hydrocortisone, polymixin B, bacitracin, and neomycin (Cortisporin). This was repeated on Sunday evening. On Monday morning, he was seen at our office with perhaps one-eighth of the cornea involved in multiple dendritic figures. Iodine cautery, followed by idoxuridine (Stoxil) ointment and idoxurine (Stoxil) drops effectively controlled the lesion in three days.

Case No. 3. An 18-month-old Caucasian girl was noted to have a small blister on the skin near the right outer canthus. This was probably her primary herpetic infection. An eye solution containing neomycin and hydrocortisone (Neohydeltrasol) drops were prescribed by her family physician and were instilled three times daily in each eye. She was also given oral penicillin.

She became very much worse in 72 hours and was seen at our office some five days after the corticosteroid was begun. There were bullous skin lesions involving all four eyelids along with much edema. Fortunately there was no conjunctival infection which would indicate that she had no corneal involvement. The drops were discontinued and idoxuridine (Stoxil) ointment prescribed. Within 48 hours she was much improved. Her subsequent course was uneventful.

Case No. 5. A 60-year-old Caucasian female was first seen in April 1966 with a complaint of pain in the left eye. Her physician had been treating her for two months with various eyedrops, including dexamethasone (Decadron) solution. Some 90 per cent of the left cornea was involved in a central corneal ulcer with dendritic margins. She was admitted to the hospital for iodine cautery. Idoxuridine (Stoxil) drops were used. She was discharged home after one week in the hospital. The cornea was very slow to heal.

Some six weeks after she was first seen, a two point tarsorrhaphy was done. Five weeks later, the cornea was healed. However she developed a severe uveitis which was very resistant to treatment. The eye gradually lost all light perception and it became necessary to enucleate the eye for relief of pain in August 1966.

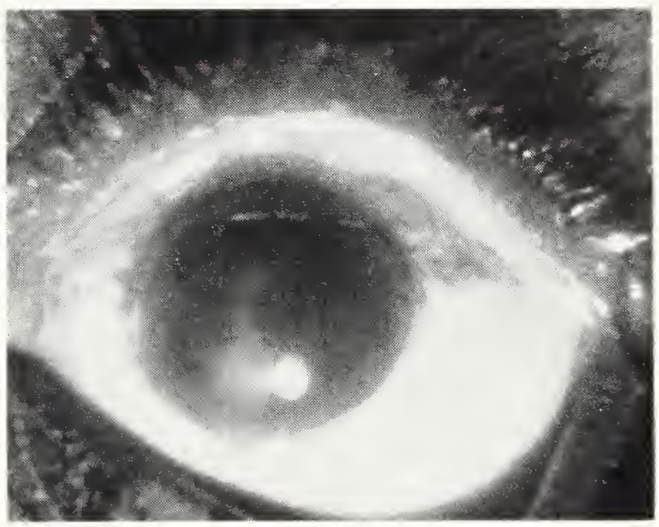


Figure 1

Case No. 6. A 19-year-old Caucasian female, a freshman in college, with a history of having had dendritic ulcers in the past, developed a painful reddened eye while in school. She was seen by a physician near the college and was given steroid drops to use in the eye (presumably the physician assumed this to be an allergy). Two days later her eye was much worse. When seen at our office she had scattered dendritic ulcers over the entire cornea. Healing occurred promptly after iodine cauterization of the cornea and idoxuridine (Stoxil) drops. There was no corneal scarring and no visual loss.

Before the advent of topical steroids, fungus infection of the cornea was an extremely rare condition. The incidence has increased greatly with the local use of antibiotics, especially tetracyclines, and particularly local steroid use. Some degree of visual impairment nearly always results after this infection. Indeed the eye may be lost.[4]

Case No. 7. A 30-year-old Caucasian male was struck in the right eye by a cotton stalk while working in the cotton field. The eye was painful during the night so that his physician was consulted on the following day. Instillation of eyedrops containing neomycin, bacitracin and polymixin B (Neosporin), was begun. Dexamethasone (Decadron) instillations were also begun. Within a few days pain was relieved but vision remained impaired. The Neosporin was discontinued after 10

days and Chloramphenicol (Chloromycetin) solution instilled. The eye remained fairly comfortable with the daily use of Decadron.

When seen in our office in March 1970, some 28 days after injury, the eye was almost white. However, there was a central corneal ulcer present, the staining area measuring some four millimeters in diameter. There were numerous satellite lesions surrounding the central ulcer. According to Vaughan and Riegelman[5] this satellite formation is an important diagnostic feature of fungal corneal ulcers. Vision was reduced in this patient to counting fingers. Culture for fungi did not reveal any growth, but this was undoubtedly a fungal ulcer.

Nystatin suspension (25,000 units per milliliter) was begun in dosages of one drop every hour when awake. In addition 30 per cent sodium sulfacetamide (Sodium Sulamyd) solution was instilled four times daily. Five days later the staining area was 50 per cent less. However, one week later the staining area remained the same. We considered the possibility of a conjunctival flap at this time. Three days later the area was cauterized lightly with 5 per cent Tri-chloroacetic acid. The Nystatin was discontinued. Sodium Sulamyd was continued. On the 26th day of treatment, the cornea was healed over and has remained so.

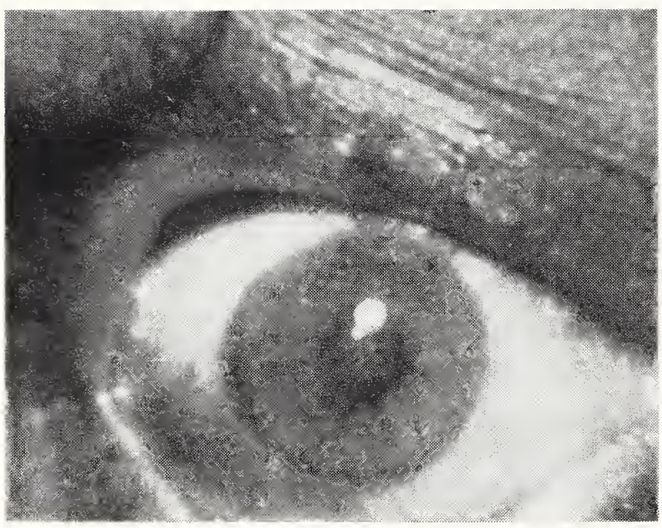


Figure 2

Figure 2 shows the eye some two and a half months after the injury. Central corneal scarring reduces vision to 20/60. Corneal transplant may be considered in the future if the central vision does not clear.

Case No. 8. A 40-year-old Caucasian male was struck in the left eye by a pine needle. There was very little pain so that he did not seek medical attention. On the following day, while on his farm, he was seen casually by a physician who gave him a sample tube of ophthalmic ointment containing dexamethasone, neomycin, and polymixin B. This was used faithfully at bedtime each night but the eye became worse.

When first seen at our office six days after the accident there was a fluffy appearing intrastromal corneal mass about one millimeter in diameter. There were a half dozen satellite lesions around the mass. The center of this area was stained with Fluorescein. On culture, scrapings from the area yielded a pure growth of *alternaria,* ordinarily a harmless saprophyte, but probably pathogenic here due to the local use of the corticosteroids.

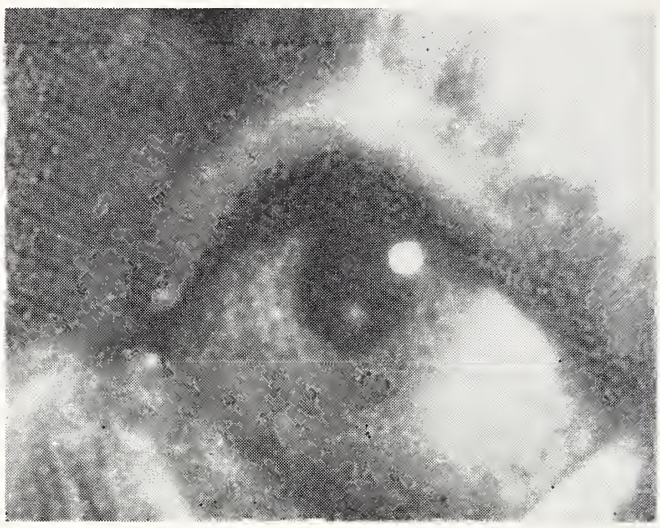


Figure 3

Treatment consisted of the topical application of 10 per cent sodium sulfacetimide (Sodium Sulamyd) solution and also topical nystatin. The nystatin was used only four times, being too painful for the patient to tolerate. Some 48 hours after he was first seen, amphotericin B solution was begun topically every two hours. He then gradually began to heal. The corneal lesion continued to stain for one week. The pupil was dilated with Atropine. Figure 3 shows the corneal lesion three days after he was first seen. The cornea was completely healed five weeks later. Vision returned to 20/20 in this eye.

Ophthalmologists have become well aware of the tendency for the intraocular pressure to rise following the use of the corticosteroids.[6–7] This seems still not to be too well known by all physicians.

Case No. 1. In 1961 a 41-year-old Caucasian female was checked at our office for glaucoma on the advice of her sister, 10 years older, who was under the treatment of an ophthalmologist in Birmingham, Alabama, for glaucoma. At this

time and again in 1963, the patient was found to have very low ocular pressure (12 Schiotz), normal discs and normal fields.

She was next seen as an emergency on October 3, 1967. She had been under treatment from several general doctors for "ocular allergy" for the past year. One physician prescribed dexamethasone (Decadron) drops for symptomatic relief. These gave so much relief that for three months she had used them twice daily in eye.

Vision corrected to 20/20 in the right and left eyes. There was slight enlargement of the right blind spot. The right tension was 35 and the left tension 30 Schiotz. The steroid was discontinued and the instillation of two drops of one-half per cent Pilocarpine solution was begun in each eye three times daily.

On October 6, 1967, the pressure had fallen to 17 Schiotz in each eye. All medication was discontinued on November 6, 1967, and her pressure has remained normal since then. This patient illustrates the danger of allowing the "steroid responders" to use steroids indiscriminantly.

This direct quotation from Dr. Ellis summarizes our feelings exactly. In answer to the question "When should ophthalmic corticosteroids be used?," Dr. Ellis writes: "I should say that unless the doctor has a special interest in ophthalmologic problems and is able to differentiate the above-described conditions, he would do well to avoid ophthalmic corticosteroids altogether! Furthermore, I should stress that antibiotic-corticosteroid products confer a false sense of security. I certainly believe that the non-specialist is qualified to treat conjunctivitis, corneal injuries, corneal foreign bodies, etc., but I feel that he should employ antibiotics *alone*. I should advise his using corticosteroids only when an acute allergic reaction is present."

SUMMARY

Dangers in the local use of corticosteroids are pointed out. Specific conditions which need to be emphasized are activation of herpes simplex lesions, production of fungal ulcers, and secondary glaucoma. Cases illustrating these conditions are presented. ★★★

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KIDS TODAY

"Upsey-wupsey!" cried the old lady cheerfully to the little boy who fell off his tricycle.

"Upsey-wupsey, my eye!" he told her. "I think I've cracked my sacroiliac!"

A New Facility for the Treatment of Burns

ROBERT T. LOVE, JR., M.D.
Greenville, Mississippi

Despite progress in care and treatment of burn patients, mortality and morbidity remain high in this type of trauma. The need for highly specialized burn units and care teams is vital. The author discusses the philosophy, organization, development, design, personnel needs and admission policies of the new burn unit at Washington County General Hospital.

MANAGEMENT OF THE BURNED patient comprises one of the most demanding forms of patient care. Although advances in acute burn resuscitation, systemic antibiotics, and topical burn wound care have taken place at a rapid rate in the past, mortality and morbidity remain predictively high. The need for highly specialized burn team care is an absolute necessity if the mortality and morbidity are going to be lowered in this particular type of trauma.[1]

Progress in burn therapy until recently has been halting and intermittent. In the past, advances in the treatment of burns were stimulated when receptive scientists and clinicians were confronted with multiple casualties from disasters. The Rialto Theatre fire of New Haven in 1921 and the 1942 Coconut Grove fire in Boston were two such occurrences.

Progress since World War II has been continuous and accelerating. The first step was the establishment of burn centers which collected large numbers of patients for constant care and study. Many physicians have received training in these centers and disseminated the advances and knowledge developed in these centers. The second development which accelerated progress was the introduction of new topical therapy of burn wounds.

Burn units have been established in response to the needs of the community, the physicians, and the hospitals. The treatment of burns is certainly no more complex than the treatment of many other surgical and medical conditions. However, the therapy is costlier to the patient and more time consuming for the physician. The major factor contributing to the higher cost of burn treatment is mainly due to the long duration of hospitalization. Whereas the average hospital stay for medical and surgical conditions is approximately 10 days, the average hospitalization for burn patients exceeds 30 days. It has been proven that patients treated in a burn unit require a significantly shorter hospitalization than those treated in general hospital facilities. It has also been shown in at least one burn unit that the average hospital stay can be reduced by as much as 50 per cent. Not only does shortened hospitalization reduce the cost of treatment, but it also minimizes the complications such as decubitus ulcers and joint contractures.

In contrast to general medical and surgical cases, the demand of a seriously burned patient on the attending physician's time is enormous. Unless a substantial portion of a patient's care is performed by ancillary personnel, a severely burned patient requires an average of two to three hours a day of a physician's time. Also, the physician is obligated for nearly constant attendance for the first 48 hours after the patient is burned. Few physicians can divert so much attention from their practice to provide such intensive care.

From the Department of Surgery, Washington County General Hospital, Greenville, Miss.

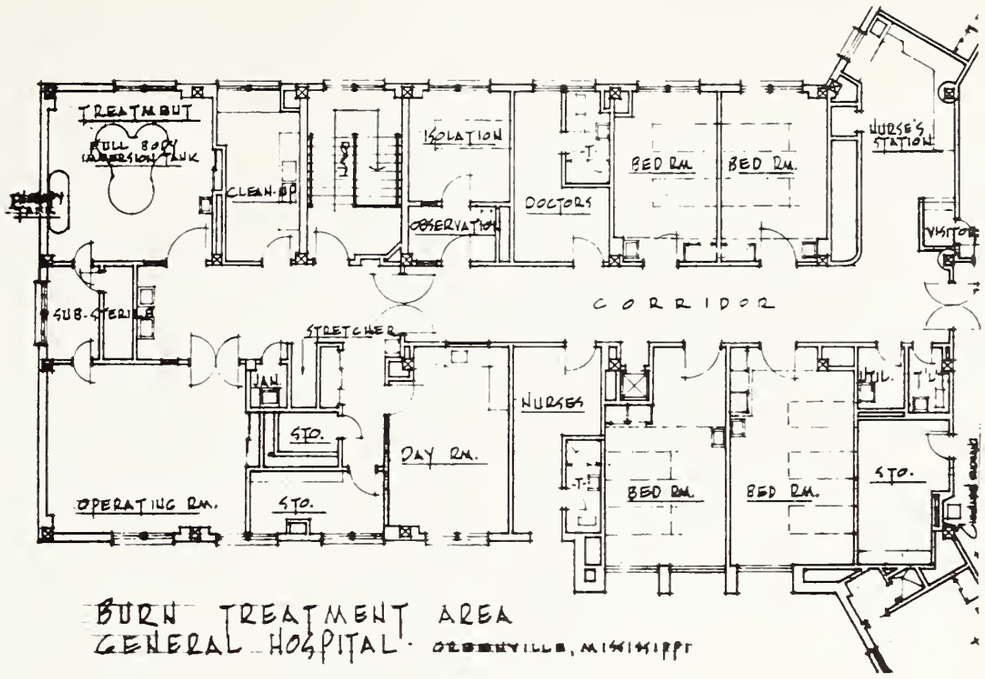


Figure 1

Quite often most practicing physicians treat burned patients infrequently and are more than glad to relinquish the care of a severely burned patient to a specialist in a burn unit.

The administration and nursing services of most hospitals are generally upset by the peculiar requirements of housing and caring for burned patients. Precautions are necessary to protect the remainder of the hospital from undue contamination. Isolation techniques tend to segregate the burned patient and render him relatively inaccessible to regular hospital personnel. Treatment in an isolated area almost always demands private duty nursing care. In spite of such precautions. other physicians do not particularly feel nonchalant about housing "clean" cases in close proximity to severe burns. Also, anticipation of damage to hospital property is of further concern. After a burned patient has been discharged from the hospital, the room and its contents must be meticulously cleansed. Some types of topical therapy such as silver nitrate can permanently stain the entire room and its contents. Some hospitals which undertake the initial care of a burned patient find it impossible to continue providing care after the patient's personal and insurance funds are depleted. At this point the hospital may seek to remove the patient to a public institution.

At present there are about 50 burn units in the United States. Burn units are being developed in various parts of the country, and as might be expected, their facilities vary quite widely from burn unit to burn unit. Quite a few of the units merely have an isolation ward without any physical therapy facilities or operating room facilities. Many burn units also have very limited space for patients. Financing of the burn units usually falls into three categories. While several units are sponsored by community hospitals, others are sponsored by federal, state, or local governments. Recent interest has also been shown by the Shrine to construct free burn units for the treatment of children. The success of any burn unit is dependent upon the strong commitment by the hospital and devotion by a dedicated medical staff which attaches priority to the burn unit. The need in a community for a burn center should be dictated by the size of population for which the center would be accessible and by the proximity of other units. Assuming that the average hospitalization is slightly in excess of one month for a burn, a community that can utilize 10 beds to near capacity can establish a burn center and treat approximately 100 patients a year. In other words, a hospital can treat the same number of burned patients that it has treated in previous years more efficiently and economically in a burn unit.

The development of a burn treatment facility involves the organization of the medical staff through recruitment and training of paramedical personnel and the construction or remodeling of the physical plant.

Administration of the unit must be entrusted to one or two physicians although admitting and attending privileges may be granted to a number of physicians on the hospital staff. Participating physicians must be prepared to treat their pa-

tients all in the same manner. This is necessary for several reasons: (1) During the absence of one physician, other doctors may assume the care of his patients, and thus the care of the patient will be congruous. (2) Simplification of nursing procedures is an absolute necessity. Nursing time in a burn unit is always at a premium. Standardization of nursing procedures reduces the time required for routine nursing procedures. (3) It is virtually impossible for any individual doctor in a community hospital burn unit to accumulate a significant number of cases for the publication of a study that would have any statistical meaning. With standardization of procedures, collective data would be readily available.[2]

The burn unit at Washington County General Hospital was developed from a pre-existing facility which had previously been used for obstetrical deliveries. The unit as shown in Figure 1 now has an operating room and a therapy room. Included in the therapy room are a Hubbard tank for full body emersion and a smaller tank for partial emersion of patients. The operating room is a fully equipped operating room of the type found in most general hospitals. A conference room is also present in the unit for the staff to discuss patients who are currently being treated in the unit. There is also a doctors' lounge and dressing room and a similar lounge and dressing room for nurses. There are five separate rooms for patients. Three of the rooms will have two patients each, and one room will have three. There will be one room which will house one patient only. Also, a very large nurses' station is present at the opposite end of the unit from the operating room. An area where patients can be visited and still be isolated from the visitors is also in close proximity to the nurses' station. The whole area is closed off by locked doors, and the patients are admitted and not allowed to leave until they are discharged from the unit.

When the unit is at full strength there will be one director of the unit and six attending staff members. Also, there will be five registered nurses and four licensed practical nurses. Nurse's aides, orderlies and housekeeping personnel will be included on the staff of this unit.

Any one of the attending staff or the director of the unit may admit patients to this unit. The attending staff are general surgeons, and the director is a plastic surgeon. Patients will be admitted by any of these physicians.

SUMMARY

Existing burn units in the United States and other countries have a high utilization rate. The unavailability of these units in many areas of the United States makes it necessary that more of these units be developed. Units that have been established are well accepted by patients and physicians alike. Progress in the science of burn treatment has progressed quite rapidly since the burn unit came into existence. Many cities of moderate size are now in the process of developing burn units.[3] ★★★

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NOTHING TO WORRY ABOUT

Patient in dentist's chair: "Hey, that wasn't the tooth I wanted pulled."

"Calm yourself. I'm coming to it!"

Address of the President

PAUL B. BRUMBY, M.D.
Lexington, Mississippi

IT HAS BEEN JUST a few days less than a year ago since this House of Delegates after much thought and consideration of the problems facing the physicians of the state gave instructions and guides to your Trustees, your committees, your executives, and your general officers for the conduct of your affairs during the past year.

Throughout the year you have heard, from every imaginable source outside of our own ranks, of the shortcomings, and only the shortcomings of medicine and its delivery system. Even Vice President Agnew exposed the fraudulent presentation of a child with meningitis as a horrible example of starvation, as was the premature baby exhibited as starvation in Mississippi at a Congressional hearing. We all are familiar with the documentary TV program that warned our citizens not to get sick in America.

We admit of certain shortcomings, and we each day ponder how these may be overcome. But can we penalize the overwhelming majority of our people for the possible good of a small minority who are rapidly becoming the political fulcrum which will detrimentally effect the practice of medicine in its entirety?

When there is a possibility of certain politicians buying the favor of our electorate with the efforts and money of others, a political issue is born. This year, it seems certain, that health care and its delivery are to be the national issues. We have our local and statewide problems made worse now by national commitment. Our only salvation is to become politically involved, as we have never become involved before. During the past session of our Legislature, over 2,000 bills were introduced, some with a great many amendments. Over 300 of these directly affected medical practice, and many others were of great significance to us. All of these required detailed study by our executives and by our Legislative Council.

Health care and its delivery are sure to be national issues this year, points out the 1970-71 president of the association. He sees the only answer as getting politically involved and says physicians must create closer understanding and an increase in cooperation with lawmakers at the local as well as state levels. Medical care foundations and national health insurance plans are also discussed.

Last year you directed that we continue the Emergency Medical Care Unit in the capitol. Frankly, reading our deteriorating image at that time, I doubted its value, but today after many doctors have contributed many days to the project, it has proved its worth many times over at this session of Legislature. It has been not only a good political investment, but the physicians who have given it their time and effort are more involved with the association as a whole.

A seemingly innocent law which would have required dose-by-dose record keeping of all drugs that might come under a drug abuse classification was passed by the House, only to be recalled and defeated. We are deeply indebted to Dr. William A. Tisdale of Biloxi, the only physician in the Legislature, for this as well as the many physicians who within a few hours contacted their representatives. But this law which would have opened your records to all law enforcement officers was unthinkable. To add additional record keeping would lay another straw on the back of the camel.

President, Mississippi State Medical Association, 1970-1971.

Read before the House of Delegates, 103rd Annual Session, Biloxi, May 3, 1971.

The problem of malpractice which weighed so heavily in our thinking last year has abated somewhat and the spectre of *res ipsa loquitur* is fading. As you remember, we were reminded that some mechanism must be afforded to counsel with and give testimony to malpractice plaintiffs or some legislative action would be in order. Our emerging peer review panels and our improved relationships with our lawmakers have resulted in our appreciation of each other. Our association will certainly honor reasonable requests from our lawyer friends.

In the many meetings of the legislative committees considering Title XIX—the Medicare Title of Public Law 89-97, there was not only a lack of those who shared our point of view, but there was definite antagonism to doctors and their position on all aspects of Medicaid. It was alleged more than once that the provider of the services to be bought by Medicaid was already rich and they would further gouge the public purse. I mention this to indicate that even here in Mississippi the public relations objectives of both the federal government and the mass media were effective.

LEGISLATIVE APPRECIATION

However, there has been one significant triumph this year, an accomplishment never before achieved. In your headquarters there is a framed resolution of the Legislature from the Speaker and the House of Representatives thanking us for the Emergency Medical Care Unit and expressing appreciation for the time and the expertise given by members of our association to individual lawmakers and their committees. This change in attitude has taken much work from each of us in our own locality, and the present meetings between our Legislative Council and the various members who make up the legislative health committees have been rewarding. There has been a closer understanding and an increase in cooperation between our members as individuals.

The government through Medicare and Medicaid, as you know, has created an inflated demand for unlimited medical services. There has been added to this the demand that medicine and its delivery, in all of its facets, should be policed either by the physician himself or some outside agency could be had to assume this responsibility. There would be some agency to guarantee the cost, the quality and the quantity of medical care. Early, the officers and our executives saw, with the AMA, in such a demand, that doctors themselves who were knowledgeable in all phases of medical care and its delivery should be the ones to give that accountability demanded by Congress for the health dollar.

Last year you established our review committee which is and has worked long and hard to effect the mechanism that would be acceptable to all third party payers. Medicare has shown interest and Medicaid has promised full cooperation with this panel, but it is to be a voluntary appellate review panel to adjudicate such claims involved in dispute, as might be referred to it. When the demand for quality and quantity are carried to their ultimate decisions there must be established norms, and these norms are now being formulated in a booklet form for hospital utilization review boards and there are definite outlines of treatment. Similar norms and guidelines of ambulatory treatment are being compiled, and we have to remember that there might well be a demand for office audits.

VOLUNTARY REVIEW

With peer review we have to sell our services of voluntarily reviewing all phases of medical practice and delivery. The acceptance of any ruling is voluntary and could not be forced on either party. To have peer review accepted by all governmental agencies and to even make them the instruments of private insurance carriers was and is the ideal situation for our state panel to operate.

In Sonoma County, California, several years ago, to furnish medical care to a great number of migrant workers and their camp followers, the local medical society decided to form a corporation or foundation that would and could bargain and contract with HEW and certain local insurance companies to be the fiscal agency through which third party payments for medical services would be made. This was an avenue through which health services could be directed. The foundation, so termed, in return would guarantee the cost, the quality and the quantity of medical care. A binding agreement was made and usual and customary fees have been paid after each bill was approved by the foundation. The trustees of this foundation were appointed by the county medical society, and the executive secretary of the society was also the secretary of the foundation.

The third party payers had previously ruled that a foundation could be set up, financed initially and they could establish guidelines and norms, and elect or appoint officers, but it could not be an integral part of a medical society itself. This, of course, was directed in preventing

the possibility of discrimination against nonmembers who themselves must use this review mechanism. The doctors who elected to belong were free agents to be chosen by patients and to choose those whom they elected to serve. The third parties pay the cost of operation of the foundation and in the two cases where a foundation was disbanded there was no penalty. With the certainty of some form of socialized medicine approaching, the freedom of choice foundations are the last chance for the practice of medicine as we now know it. There are between 25 and 35 foundations using various formats. Georgia, Iowa and New York have recently formed foundations and Louisiana only recently sent their executives to the San Joaquin Foundation to discuss the possibility of having their foundation administer the upcoming family planning program.

We have the office space, the hardware, the personnel, and the expertise to have an ongoing peer review committee simply formed as a foundation, and we are in business ahead of the rush to socialized medicine, however, even Teddy Kennedy says he can use medical foundations in his scheme. These foundations, then, are organized, staffed and directed by local medical societies guaranteeing to the government that accountability demanded, agreeing to review all claims not just those which might bear suspicion. This foundation agreed to provide from their membership quality medical care to meet the needs of those for whom the particular third party is responsible. Most foundations have 90 per cent of the practicing physician enrolled. In every state there is deep study of this as a solution to the web being spun around our professional activities.

HIMLER REPORT

A year ago the Himler Report was much in our minds. The House of Delegates of the AMA disposed of the recommendations, by fragmenting them through several committees. This year we feel that the demand for some form of national health insurance will force this issue, and we hasten to try with all of our political power and skill to have enacted our own Medicredit proposal which would leave intact the free choice of physician and the present physician-patient relationship. We would furnish quality medical care to those unable to afford quality care and as a negative income tax, the poor would receive free care, and as the family income increased the government would pay a smaller part of its cost. The government would decrease their contribution as an income tax deduction until finally 10 per cent of a given tax liability would be allowed for the purchase of comprehensive health coverage. This final 10 per cent is usually considered the cost of insurance which at present is tax deductible. A corridor or an escalating sum must be expended by subscribers before the balance is to be paid from catastrophic insurance funds. These corridor amounts are all calculated from the sum of any tax liability.

Medicredit is the only proposed national insurance scheme which would not completely restructure the whole of medical care delivery. Senator Kennedy has at this time his committee—his show on the road, giving in each principal city a forum for labor and discontents to attack the present health care system. The distressing fact about his completely socializing so-called health security scheme is that it is to be patterned after that in England where Senator Kennedy plans to take his committee to see first hand the beauty of this system. The tragedy is that 24 of the committee of 100 who are so completely backing Senator Kennedy are physicians. You wonder if this committee will be told that 33⅓ per cent of all English medical graduates refuse to practice in England, and that the only providers of medical care come in the colors of the rainbow in that tight Anglo-Saxon island.

AHA PLAN

I would mention in passing that the medical care corporation advocated by the American Hospital Association would be governed by a board consisting of equal numbers of hospital administrators, hospital trustees and physicians. It would be a capitation scheme governmentally financed and hospital oriented. We will hear much about President Nixon's HMO as the mechanism for health delivery. These are closed panels, capitation financed, and supported by a government funded private insurance organization called Family Health Insurance Plan, and an additional insurance, the National Health Insurance Standard Act would be financed by employers paying 65 per cent of the cost of a government approved standardized hospital and health policy, while the employees pay 35 per cent. This 35 per cent will decrease within five years to 25 per cent. Thus the employer of one or more people would pay $230 of the calculated $370 cost. This, of course, would be inflationary and would cripple many small and marginal employers. All schemes provide for some catastrophic protection. Somewhere between these projected schemes you can see your future, and from the many new medical schools subsidized according to the students *graduated* you can see the manpower. During the past year there has been much greater effort

made by your headquarters to work with the Mississippi Hospital Association and we have closed some of the gaps between our objectives. The physicians in Mississippi, the trustees of the hospitals in Mississippi and the hospital administrators in Mississippi would have a great deal of political power. Every effort is being made by the Mississippi Hospital Association to form a tight organization of the hospital trustees throughout the state.

The greatest strength of our organization is the completely dedicated service of your trustees, your committeemen, and your executive staff. It might be disheartening at times to see the apparent apathy at the local level, but I have been told repeatedly that this is a vote of confidence in those in policy making positions. Our society would like it a great deal better with a hundred times more of our members involved in these decisions.

There has been discussion at great length about the possible fragmentation of the association by the enthusiasm of the increasing number of specialty societies. With the change in hospital staff requirements, with the impetus placed on continuing education by our society, the medical center, and the increased demand of time and thought by the general officers and trustees on matters of socioeconomic importance, the scientific presentations could well be placed in the hands of these bodies and the thrust of our survival in the private delivery of medical care remains in the hands of our delegates who can through their representatives watch more closely the development of this certain restructuring of our profession. This can and will but make of us a closer knit organization. This House of Delegates for the past 102 sessions has grappled with the problems of patient care and physician survival. Your decisions have been wise. The 103rd Annual Session will be no exception. ★★★

102 Carrollton Street (39095)

MIDAS TOUCH

The town was honoring its only physician on the occasion of his 50th year of practice. Curious over the doctor's affluence, the mayor of the community asked:

"Doctor, it's well-known here that you are worth a million dollars. To what do you attribute your great success?"

Hesitating a moment, the physician replied: "First, I attribute it to hard work and diligent care of my patients. Second, I attribute it to charging reasonable fees and seeing to it that they are paid.

"And third," he continued, "I attribute much of my success and wealth to my late Uncle Harry who died and left me $990,-000."

Constitution and By-Laws of the Mississippi State Medical Association

CONSTITUTION

Preamble

That more may live longer in the richness and comfort of health; that pain, suffering, and disease may be eradicated to the extent made possible by scientific medical knowledge; that the standards of the medical profession may be maintained on the highest plane of honor, we dedicate ourselves as physicians through this Association. Among us, membership is a privilege, earned by professional qualification, personal honor, and selfless service; it is not a right vested superficially nor by statutory licensure. Truth shall be our quest; diligence, our staff; and service, our purpose.

Article I

NAME OF THE ASSOCIATION

The name and title of this Association shall be the Mississippi State Medical Association.

Article II

PURPOSE OF ORGANIZATION

The purpose of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Mississippi and to unite with similar associations in other states to form the American Medical Association, with a view toward the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws. to the promotion of friendly intercourse among the physicians and to guarding and fostering of their opinion in regard to the great problems of medicine, so that the profession shall become more honorable and capable within itself, and more useful to the public in the prevention and care of disease, and in the prolonging of and adding comfort to life.

The purpose of this Association shall be to promote scientific medical research and practice and it shall be a non-profit organization.

Article III

COMPONENT SOCIETIES

Component Societies shall consist of those societies which hold charters from the Association.

Article IV

MEMBERSHIP

Section 1. Members of the Mississippi State Medical Association. Members shall be active, associate, or emeritus, acording to requirements and provisions of the By-Laws. There may also be invited guests. Membership other than associate shall be construed as active in connection with the rights and privileges accruing therefrom.

Section 2. Guests. Any physician not a resident of the state may become a guest during any annual session upon invitation of a member of the Association, and shall be accorded the privilege of participating in all the scientific work of that session.

Article V

SESSIONS AND MEETINGS

Section 1. The Association shall hold an annual session during which there shall be held daily not less than two general meetings, which shall be open to all registered members and guests.

Section 2. The time and place for holding the annual session shall be fixed by the House of Delegates, but in emergencies, the Board of Trustees shall have the power to fix, or change, either the time or the place, or both of the annual session.

Article VI

GENERAL OFFICERS

Section 1. The general officers of this Association shall be a President, President-elect, three Vice-Presidents, one from each Supreme Court District, Secretary-Treasurer, Speaker, Vice Speaker, and Editor.

Section 2. The President, President-elect, and Vice-Presidents shall hold terms of one year. The Secretary-Treasurer, Speaker, Vice Speaker and Editor shall be elected for terms of three years.

Section 3. The officers of this Association shall be elected by the House of Delegates on the last day of the annual session following the adjournment of the general meeting, but no person shall be elected to any such office who has failed to attend two-thirds of the past two and current annual sessions and who has not been a member for the past two years.

Section 4. In addition to these general officers, there shall be an Executive Secretary who need not be a physician or member of the Association. He shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. His compensation and expenses for duties performed shall be fixed by the Board of Trustees and confirmed by the House of Delegates.

Article VII

EXECUTIVE OR CENTRAL OFFICES

The Executive Secretary shall maintain in the city of Jackson suitable offices for the discharge of his duties and for conducting the administrative affairs of the Association.

Article VIII

HOUSE OF DELEGATES

The House of Delegates shall be the legislative, business, and policy-making body of the Association and shall consist of (1) delegates selected by the component societies under authorized apportionment, (2) the general officers of the Association, (3) all past presidents, provided they still be members in good standing of the Association, (4) members of the Board of Trustees and Councils, and (5) elected committees, Delegates and Alternate Delegates to the American Medical Association, members of the State Board of Health, and members of the Board of Trustees of Mental Institutions, all of whom must be members of this Association.

Article IX

BOARD OF TRUSTEES

The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates and shall perform such duties as are prescribed by law governing directors of corporations and in the By-Laws of the Association. The Board shall consist of nine members, one from each Association District, elected for terms of three years each. A Trustee shall not serve more than three consecutive terms.

Article X

FUNDS AND EXPENSES

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by annual dues, per capita assessments upon the membership, and by voluntary contributions. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, publications, and for any other purpose approved by the House of Delegates.

Article XI

THE SEAL

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each component society at least two months before the session at which final action is taken.

BY-LAWS

Chapter I

MEMBERSHIP

Section 1. Eligibility. Each component society of the Mississippi State Medical Association shall judge the qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriately accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate must be legally licensed to practice medicine in Mississippi. Persons who obtained this degree prior to January 1, 1917, need not comply with this requirement but must be licensed to practice medicine in Mississippi or, if offering to practice in Mississippi must be eligible for license by reciprocity and be a member in good standing of a constituent (state) association of the American Medical Association. Membership in a component society, evidenced by the payment of dues for the current year, shall be a prerequisite to membership in the Association, except that a physician upon his initial application for membership in a component society of the Association shall be required to undergo a waiting period of ninety (90) consecutive days from the date he begins the practice of medicine in the geographical area of the component society before he may be elected to membership in the component society. No physician shall be eligible for membership who has been convicted of or who has plead guilty to either a felony or a violation of a state or federal narcotics law. The duly certified court record shall be *prima facie* evidence of pleas and convictions and cause automatic revocation of membership. No physician shall be eligible for election to or continuation of membership who does not possess a currently effective federal narcotics stamp, provided, however, that physicians in full time government service who need no registration to use, prescribe, and dispense narcotic drugs and those who, by reason of type of practice, employment, inactivity, or retirement, neither prescribe nor dispense narcotics and who for this reason alone have not applied for registration shall be exempt from this requirement.

Section 2 (a). Good Standing. Only those members in good standing shall be entitled to the rights and privileges of membership. A physician not in good standing may not be elected to office nor exercise the privilege of voting or attending any session of this Association, scientific or otherwise. The name of a physician upon the properly certified roster of a component society which has paid its annual assessment shall be *prima facie* evidence of his right to register at the annual session of the Mississippi State Medical Association. No member shall participate in any of the proceedings of the annual session until he is duly registered. No delegate or other member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section. (b) Change of State Residence. In the event that a member moves from the State, his membership shall continue until, and lapse at the end of, the current fiscal year, but this provision shall not operate to prevent a physician who moves from the state continuing his membership by payment of all dues and assessments to the state Association. (c) Obligations of Membership. When the Executive Secretary of the Mississippi State Medical Association is officially informed by the secretary of a component society that a physician is not in good standing in the component society, he shall remove the name of the physician from the rolls of the Association. A member shall hold his membership through the component society in the jurisdiction of which he practices, provided that a physician living on or near a county line may hold membership in the society most convenient for him to attend. If the society in which he chooses to secure membership does not exercise jurisdiction over the area of his residence, then permission must be obtained from the jurisdiction society to facilitate his affiliation with the extra-jurisdiction society.

Section 3. Degrees of Membership. Members of the Mississippi State Medical Association shall be divided into the following classifications: Active, emeritus, and associate. (a) Active Membership. Active members shall include all eligible members of component societies in good standing, providing that all dues and assessments in this Association as may be hereinafter prescribed have been received by the Association. (b) Emeritus Members. Any members of the Mississippi State Medical Association who has been an active member for any ten consecutive years and shall have permanently retired from the practice of medicine shall be eligible for election to emeritus membership. Election to emeritus membership for reason of retirement in the case of permanent and total disability shall merit special consideration but shall be subject to ruling by the Board of Trustees. Election to emeritus membership shall be based on the recommendation of the component society and the approval of the Board of Trustees. (c) Associate Membership. Any commissioned medical officer in the United States Army, United States Air Force, United States Navy, or United States Public Health Service, or any physician in the employ of the Veterans Administration, not licensed to practice in the State of Mississippi, stationed in Mississippi, members of medical faculties of medical schools in Mississippi, approved by the American Medical Association, who are not licensed to practice in the state, any hospital intern, or any hos-

pital resident in Mississippi, may, on election to associate membership by the component society in whose jurisdiction the physician resides become an associate of the Mississippi State Medical Association. Associate members shall not vote or hold office.

Section 4. Dues and Assessments. A per capita assessment determined by the House of Delegates shall constitute the dues of the Association, which assessment shall be collected from all active members by the respective secretaries of the component societies, provided that new members shall be accepted on payment of three-fourths of annual dues after May 1 and one-half of annual dues after September 1. Each active member shall pay the prescribed dues to the officer designated by the component society for transmittal to the Executive Secretary of the Association. Dues shall include a subscription to the official publication of the Association. (a) Members Excused From Payment. The Board of Trustees may, by majority vote, excuse a member from payment of dues because of undue hardship or similar circumstances warranting special consideration provided that the component society shall have excused in full the payment of dues for periods exceeding one year. Such circumstances shall be interpreted to include extended illness and temporary disability. Members who shall have attained age 70 and who have been active members of the Association for any 10 consecutive years may, upon request, be exempt from dues for life effective January 1 after the 70th birthday, and such exemption shall continue so long as the member continues in good standing in his component medical society. (b) Emeritus Members. Physicians who have been elected emeritus members shall not be required to pay dues in the Association. (c) Payment of Dues and Delinquency. Dues of the Association are due and payable on December 31 of the year prior to that for which dues are prescribed. Failure to pay dues by April 1 of the year for which due shall result in forfeiture of membership privileges and the removal of the member's name from the rolls of the Association. A five dollar ($5.00) reinstatement cost shall be assessed against any member who is delinquent by reason of non-payment of dues after April 1 of the year for which dues are payable. A member in good standing who is called to active duty with the Armed Forces of the United States other than in the regular component shall be carried as an active member without payment of dues until such time as he is released from military service.

Section 5. American Medical Association. Members of this association desiring to be members of the American Medical Association may pay the dues or apply when eligible, for legal exemption from the dues of the American Medical Association. Those desiring to do so may pay their dues to the Executive Secretary whose duty shall be to transmit them to the American Medical Association and to obtain proper credits and receipts therefor.[1]

Section 6. Revocation of Emeritus or Associate Membership. Any emeritus or associate membership may be revoked by two-thirds vote of the House of Delegates when, in the opinion of the House of Delegates, the conduct or actions of the emeritus or associate member violates any of the principles of the code of ethics or whose conduct or actions are not becoming to the honor conferred.

Chapter II

ANNUAL AND SPECIAL SESSIONS

Section 1. Time and Place. An annual session shall be held as required by Article V, Section 1, the Constitution of the Mississippi State Medical Association. which session shall in any event be held prior to the annual session of the American Medical Association. The place of the state session shall be fixed in accordance with Article V, Section 2, the Constitution of the Mississippi State Medical Association.

Section 2. Special Session. A special session of the Association or of the House of Delegates may be called by the President, with the approval of the Board of Trustees. The Board of Trustees is empowered to call a special session by majority concurrence.

Section 3. Inviting an Annual Session. A component society desiring the Association and House of Delegates to meet in annual session in a city within its jurisdiction may submit an invitation in writing or verbally through its representative to the House of Delegates at the annual session concerned with the selection of the site for the next regular scheduled meeting. The dates and site of the annual session selected may be changed by majority vote of the Board of Trustees in an emergency requiring such a change.

Section 4. Registration Privileges. Only the following shall be permitted to register at any session:

(a) Active members
(b) Emeritus members
(c) Associate members
(d) Invited guests
(e) Medical students of American Medical Association approved medical schools who are certified to the Executive Secretary of the Association by their respective deans.
(f) Interns and residents who are graduates of American Medical Association approved medical schools and who are connected with an approved hospital and who are certified to the Executive Secretary of the Association by their respective hospital superintendents in event they are not associate members of the Association.
(g) Commissioned medical officers of the United States Armed Forces who are on active duty and who if not associate members are certified to the Executive Secretary by their Post or Base Surgeons or Commanding Officers.

Section 5. Indebtedness. A member shall not be permitted to register unless all current indebtedness to both the Association and component of proper jurisdiction has been paid.

Section 6. Admittance. Admittance to any meeting of the House of Delegates, any scientific section, or any of the various exhibits at an annual session of the Association shall be limited to members in good standing, duly registered and invited guests, members in good standing of the Woman's Auxiliary to the Mississippi State Medical Association, duly accredited and registered members of the Press, and accredited technical and scientific exhibitors.

Chapter III

GENERAL MEETING

Section 1. Participation. The general meeting shall include all registered members and guests, who shall have equal rights to participate in the proceedings and discussions, but no member shall vote on any question coming before a section of the general meeting except those who have registered as members of such sections. Each section of the general meeting shall be presided over by its chairman. The address of the President and the Distinguished Service Oration shall be delivered before the general meeting at such time and place as may be arranged.

Section 2. Order. The order of exercise, papers, and discussions as set forth in the official program shall be followed from day to day until it has been completed. But no section shall be allowed to place more than five papers on its program, nor more than two invited guest essayists (out-of-state or non-member). When a section program is not completed within the time assigned, it shall not be allowed to continue into that assigned to another section.

Section 3. Time Restrictions. No address or paper before the Association, except those of the President

[1] To become effective Jan. 1, 1972, for the 1972 membership year.

and Orator, shall occupy more than twenty minutes in its delivery, except that guests may be allowed thirty minutes; and in formal discussion no one shall speak more than five minutes; and in informal discussion no one shall speak more than three minutes and not more than one time.

Section 4. Essayists. With the exception of the invited guests, the essayists must be members of the Association. No name shall appear more than once on the printed program to discuss a paper before the regular scientific sections unless such person qualifies for membership as provided in these By-Laws.

Section 5. Papers. All papers read before the Association shall be its property. Each paper must be read by its author, and must be deposited with the Secretary when read.

Section 6. Failure to Read Paper. No author listed on the program who fails to read a paper at the session may be allowed a place on the program of the next annual session, but if the author, being unable to attend, shows his good intent by forwarding his paper to the Secretary before the annual session, he shall not suffer the penalty.

Chapter IV
SCIENTIFIC SECTIONS

Section 1. Designation of Sections. The scientific sections of the Association shall be as follows: (a) Section on Medicine, (b) Section on Surgery, (c) Section on Preventive Medicine, (d) Section on Eye, Ear, Nose and Throat, (e) Section on Pediatrics, (f) Section on Obstetrics and Gynecology, and (g) Section on General Practice.

Section 2. Section Officers. Each scientific section of the Association shall, as the last order of business during its regular meeting, elect a chairman who shall serve for a period of one year. A majority of votes cast shall be necessary to elect. Additionally, each section shall elect a secretary whose term of office shall be for a period of three years and so arranged that secretaries shall be elected by their respective sections at the same annual meeting as follows: (1) Sections on General Practice and EENT, (2) Sections on Obstetrics and Gynecology and Preventive Medicine, and (3) Sections on Pediatrics, Surgery, and Medicine.

Section 3. Program. The Council on Scientific Assembly shall place any paper in its proper section. The Council shall so arrange the program that no one section shall be given precedence over others two years in succession.

Chapter V
HOUSE OF DELEGATES

Section 1. Apportionment and Representation. Each organized county shall be entitled to representation in all regular and special sessions of the House of Delegates, one delegate and one alternate for each fifty members in the county and one delegate and one alternate for each fraction thereof, but each organized county holding a charter from this organization having made its annual report and paid its assessments, as provided in this Constitution and By-Laws shall be entitled to at least one delegate and alternate, said alternate delegates to act only in the absence of the delegate or delegates from the respective counties. No county in a component society shall be without representation in the House of Delegates; each shall be entitled to one delegate and one alternate without regard to total membership. No alternate may be seated at any regular or special session of the House of Delegates unless the delegates elected from that county shall be absent or otherwise unable to participate in the proceedings. In the event that neither the delegate nor the alternate is able to attend the regular or special session to which they have been accredited, then any *bona fide* resident of the county may, if properly registered, qualify himself as a delegate. No representative of the component society shall be seated in the House of Delegates until all his dues, assessments, and obligations to the component society have been paid. Delegates and alternates shall be elected by their respective component societies for terms of not less than two years and shall assume office on the first day of the annual session following their elections; they shall be *bona fide* residents of the counties which they represent. Their names shall be reported to the Central Office of the Association not later than thirty days prior to the first day of the annual session. Representatives of component societies shall be seated in the House of Delegates only following their proper registration of credentials from the component societies they represent.

Section 2. Meetings and Attendance. The House of Delegates shall meet annually on the first day of the annual session of the Association. The House of Delegates shall meet for the conclusion of business on the last day of the annual session immediately following the adjournment of the last general or scientific session, provided that these requirements shall not operate to prevent such other meetings of the House of Delegates during the annual session as the House itself may order or the President or Speaker may deem necessary, but no such meetings may be called at times which would conflict with the scheduled general or scientific session. Duly registered members and guests may attend all meetings of the House of Delegates provided that they occupy a distinctly separate section of the meeting hall or auditorium and further provided that they shall not be permitted to participate in any phase of the meeting of the House of Delegates except on invitation of that body. By majority vote, the House of Delegates may enter into executive session, during which time only qualified delegates and officers of the Association may remain in attendance.

Section 3. Quorum. A three-fifths majority of registered and duly seated delegates of this Association shall constitute a quorum.

Section 4. Order of Business. The order of business shall be conducted at the pleasure of the House of Delegates, provided it shall not be in conflict with either these By-Laws or the Constitution. Meetings shall be conducted according to *Sturgis Standard Code of Parliamentary Procedure,* and within the bounds of courtesy and this Constitution and By-Laws. Generally, the order of business shall be:

(1) Adoption of the Transactions of the previous meeting.
(2) Reports of Boards, Councils and Committees.
(3) Reports of Presidential Committees.
(4) Special Orders.
(5) Unfinished Business.
(6) New Business.

Section 5. Memorials and Resolutions. No memorials or resolutions shall at any time be issued in the name of the Mississippi State Medical Association by any officer or member thereof until such memorial or resolution has been approved and adopted by the House of Delegates or Board of Trustees.

Section 6. Duties and Responsibilities. It shall, through its officers and otherwise, give diligent attention to foster the scientific work and spirit of the Association, and shall constantly study and strive to make each annual session a stepping stone to future ones of higher interest. It shall consider and advise the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto. It shall make careful inquiry into the condition of the profession of each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in the counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every

physician in every county in the state has been brought under medical society influence. It shall encourage postgraduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the component societies. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, the term of office to begin on January 1 of the year following that of the elections and continuing for two successive years. It shall, upon recommendation of the Board of Trustees, provide and issue charters to counties organized to conform to the spirit of the Constitution and By-Laws.

Section 7. Reference Committees. Business brought before the House of Delegates will normally be referred by the Speaker for hearing, debate, and recommendation to a reference committee. Sufficient reference committees shall be appointed by the President to expedite and assist in the deliberations of the House of Delegates. Such committees shall consist of not less than three nor more than five members, all of whom shall be members of the House of Delegates, who shall serve only during the regular or special session for which appointed. Any member of the Association shall have the privilege of appearing before a reference committee on any issue being considered. Additionally, reference committees may permit the appearance of any individual who, in the opinion of the committee, can assist its deliberations.

Chapter VI

ELECTION OF OFFICERS

Section 1. Ballot. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect.

Section 2. Nominations. The House of Delegates on the first day of the annual session shall select a Committee on Nominations consisting of nine members of the House of Delegates, one from each Association District. It shall be the duty of this committee to consult with the members of the Association and to hold one or more meetings at which the best interests of the Association and of the profession of the state for the ensuing year shall be carefully considered. The committee shall nominate to the House of Delegates three names for each general officer vacancy and two names for all other offices. No two candidates for President-elect may be named from the same county. Nominations for appointment to membership on the Mississippi State Board of Health shall be made by the House of Delegates in accordance with Section 7024, Mississippi Code of 1942, provided that six names shall be submitted, three of whom shall be elected and their names submitted to the Governor as nominees from each district, provided no member shall be nominated who has served two consecutive terms. The House of Delegates shall nominate five physicians when vacancies occur on the Board of Trustees of Mental Institutions which nominations shall be submitted to the Governor in accordance with law.

Section 3. Report of Nominations. The House of Delegates shall receive the report of the Committee on Nominations and elect officers, Trustees, and Council members on the last day of the annual session.

Section 4. Nominations from the Floor. Nothing in this Chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 5. Executive Secretary. The Board of Trustees shall select and appoint an Executive Secretary as elsewhere prescribed in the Constitution and By-Laws of the Association.

Chapter VII

DUTIES OF OFFICERS

Section 1. President. The President shall have general supervision over all meetings of the various bodies of the Association, shall appoint all committees not otherwise provided for, shall deliver an annual address at such time and place as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall fill by appointment all vacancies occurring during his tenure of office among the general officers and on the Board of Trustees and Councils and shall be empowered to appoint such committees on an *ad hoc* basis as may be desired or required to conduct the affairs of the Association. He shall be an *ex officio* member of all Councils and committees. He shall be the real and acknowledged head, as well as the personal representative, of the medical profession of the State of Mississippi during his term of office, and insofar as practicable, shall visit by appointment the various sections of the state and the component societies of the Mississippi State Medical Association and assist the Trustees in their tasks of aiding and strengthening the component societies and in making their work more useful.

Section 2. President-elect. The President-elect shall be in charge of the work of organization, including membership, under the direction of the President, and shall exercise these duties and advise with the Vice Presidents and with the Board of Trustees in this phase of their activity. He shall be an *ex-officio* member of all Councils and committees. He shall succeed to the presidency upon the event of the death, resignation, or removal from office of the President. This automatic succession shall not operate to disqualify him from serving the next regular term of office unless he has served more than six months as President.

Section 3. Vice Presidents. The Vice Presidents shall assist the President in the discharge of his duties. They shall further assist the President-elect in the work of organization, including membership in their respective areas, and in promoting the welfare of the Association and the profession of the state.

Section 4. Speaker. A Speaker shall be elected for a term of three years. This officer may be chosen from the membership of the Association, irrespective of any affiliation with the House. The Speaker shall familiarize himself with the rules and usages of parliamentary procedure, with the laws of the House. On him shall devolve the duty of bringing before the House through the various officers and chairmen all reports and other matters that are to receive its attention. He shall preside at all meetings of the House and perform the duties usual to the position and office of chairman except in the appointment of committees, which shall be the privilege of the President.

Section 5. Vice Speaker. A Vice Speaker shall be elected for a term of three years to run concurrently with that of the Speaker. The Vice Speaker shall assist the Speaker in all duties prescribed in these By-Laws.

Section 6. Secretary-Treasurer. The Secretary-Treasurer shall be elected for a term of three years. He shall perform such duties ordinarily devolving on a secretary of a corporation by law, custom, or parliamentary usage and shall enjoy the rights and perform such other duties as may be granted or imposed in the Constitution and these By-Laws. He may delegate such duties as are herein described to the Executive Secretary who shall be responsible therefor. He shall be an *ex-officio* member of all Councils and committees.

Section 7. Executive Secretary. The Executive Secretary shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. He need not be a member of the Association nor a physician. He shall maintain a Central Office for the Association and shall be responsible for the management and proper functioning of the Central Office to the President of the Association and the Board of Trustees. He shall attend all sessions and meetings of the Association, the House of Delegates,

the Board of Trustees, and shall serve at all times to perform such other duties as may be deemed beneficial to the Association by the President and Board of Trustees. He shall assist elected officers, Councils, committees, and Trustees in the performance of their duties. Under instructions from the President, he shall conduct a comprehensive program of public education and all such other activities as may disclose favorably to the public at large the aims, objectives, and goals of service of the medical profession in Mississippi. He shall, when requested, place himself in position to assist any of the component societies of the Association and he shall attend meetings of the component societies when invited by officers thereof. He shall be made custodian of records, books and papers belonging to the Association and he shall keep account of and promptly place under the supervision of the Secretary-Treasurer such funds as may be delivered into his hands in the name of the Association. He shall give bond at the expense of the Association in such amount as may be required. He shall provide for the registration of the members and delegates at the annual session and cooperate in preparing for and arranging all functions of the Association, including the annual session. He shall procure an exact transcript of all proceedings of the House of Delegates. He shall maintain a register of all legal practitioners in Mississippi and he shall maintain detailed and exact records of the membership with regard to component societies, the Mississippi State Medical Association, and the American Medical Association. He shall issue evidence of membership to each physician who pays the annual assessment and is accepted in the Mississippi State Medical Association. He shall maintain close and complete liaison with the American Medical Association and shall keep the component societies informed of activities, programs, and mandates of both the state Association and the American Medical Association. He shall publish from the Central Office such memoranda, bulletins, and miscellaneous publications as may be directed by the President, the Board of Trustees, and the House of Delegates. He shall conduct the official correspondence of the Association as he may be directed. He shall employ such assistants as may be required, upon authorization of the Board of Trustees. He shall supply each component society with blank forms to be used in connection with membership and reports. He shall maintain records of monies paid by the component societies for assessments and dues. He shall prepare and publish under the direction of the President and Board of Trustees such programs as may be necessary for official functions of the Association. He shall be reimbursed for expenses incurred in the performance of his duties, separately and in addition to his regular compensation.

Chapter VIII

BOARD OF TRUSTEES

Section 1. Board of Trustees. The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates. It shall consist of nine members, one from each Association District, where terms of office shall be three years and so arranged that only three members are elected annually. A Trustee shall not serve more than three consecutive terms. During vacation, the Board of Trustees shall exercise the powers conferred upon the House of Delegates by the Constitution and these By-Laws, provided that in the exercise of these powers thus conferred, the Board of Trustees shall neither consider nor act to contravene any action, mandate, or policy of the House of Delegates which may still be in effect.

Section 2. Officers of the Board. The Board of Trustees shall elect from its membership a Chairman, a Vice Chairman, and a Secretary for terms of one year during the last day of the annual session following adjournment of the House of Delegates. These officers of the Board shall compose its Executive Committee. The duties of the Secretary may be delegated to the Executive Secretary who shall maintain such special records and transcripts of meetings as the Board may desire.

Section 3. Meetings of the Board. The Board of Trustees shall meet daily during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of any three members of the Board.

Section 4. Executive Committee. The Executive Committee of the Board of Trustees shall be empowered to act in behalf of the Board on all matters delegated to it by majority vote of the Board. The acts of the Executive Committee, however, shall be subject to confirmation by the Board.

Section 5. Reports of the Board of Trustees. The Board of Trustees shall make an annual report to the House of Delegates and such supplemental reports as necessity may require at a time designated in the regular transaction of the business of the House. The report shall be made by the Chairman, the Vice Chairman, the Secretary, or the Executive Secretary. The reports of the Board shall be made a portion of the annual transactions and proceedings of the Association.

Section 6. Duties of Trustees. Each Trustee shall be organizer and arbiter for his Association District. He shall visit the component medical societies within his District during each year and shall make an annual report of his activities and of the condition of the medical profession of each county of his District. Each Trustee shall be reimbursed for expenses incurred by him in traveling within his District or attending special meetings in the performance of his official duties, which will be allowed upon presentation of an itemized and documented account. This provision shall not be construed to include his expenses in attending the annual session of the Association.

Section 7. Public Policy. The Board of Trustees shall have the right to communicate the views of the medical profession and of the Association in the State of Mississippi with regard to matters of medical science, health, sanitation, and allied spheres of activity. It shall approve all memorials and resolutions issued but shall not issue memorials and resolutions heretofore prohibited in these By-Laws.

Section 8. Association Districts. The State of Mississippi shall be subdivided into Association Districts by counties, provided that all counties in a component society shall be in one Association District. These districts are defined as follows:

District 1: Bolivar, Coahoma, Humphreys, Leflore, Quitman, Sunflower, Tallahatchie, Tunica, and Washington.
District 2: Benton, DeSoto, Lafayette, Marshall, Panola, Tate, Tippah, and Yalobusha.
District 3: Alcorn, Calhoun, Chickasaw, Clay, Itawamba, Lee, Lowndes, Monroe, Noxubee, Oktibbeha, Pontotoc, Prentiss, Tishomingo, and Union.
District 4: Attala, Carrol, Choctaw, Grenada, Holmes, Montgomery, and Webster.
District 5: Hinds, Issaquena, Leake, Madison, Rankin, Scott, Sharkey, Simpson, Smith, Warren, and Yazoo.
District 6: Clark, Kemper, Lauderdale, Neshoba, Newton, and Winston.
District 7: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, and Wayne.
District 8: Adams, Amite, Claiborne, Copiah, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, and Wilkinson.
District 9: Hancock, Harrison, Jackson, and Stone.

Chapter IX

COUNCILS

Section 1. Councils. Councils of the Association shall be elected standing bodies of the House of Delegates, responsible thereto. There shall be a Council on Medical

Service, a Council on Scientific Assembly, a Judicial Council, a Council on Constitution and By-Laws, a Council on Legislation, a Council on Budget and Finance, an Editorial Council, and a Council on Medical Education. A Council member shall not serve more than three consecutive terms.

Section 2. Council on Medical Service. The Council on Medical Service shall be charged with the responsibilities of ascertaining and studying all aspects of medical care in Mississippi. It shall examine and make available all facts, data, and opinion on timely and adequate medical care. It shall investigate social and economic aspects of medical care and report its evaluations and findings. It shall suggest means of distribution of adequate quality medical service to the public consistent with the policies of the Association. It shall act as a factfinding and advisory body of the Association. Under its jurisdictions, there shall be assigned the activities of the Association in medical service, emergency service programs, indigent care, and allied medical agencies. There shall be one member from each Association District elected for a term of three years and so arranged that only three members shall be elected for full terms each year. The Council on Medical Service shall appoint Committees on Occupational Health, Maternal and Child Care, Mental Health, and Blood and Blood Banking. Each committee shall consist of not less than five nor more than seven members appointed for periods of not less than one nor more than three years.

Section 3. Council on Scientific Assembly. The Council on Scientific Assembly shall be composed of the Secretary-Treasurer and the chairman and secretaries of the several scientific sections. The Secretary-Treasurer shall be chairman of the Council. Upon this Council shall devolve the duties and responsibilities of planning the annual session to include all scientific activity and the programming and scheduling of annual session events. The Council shall be empowered to appoint such committees for terms not to exceed one year as may be necessary to assist in the discharge of these duties.

Section 4. Judicial Council. The Judicial Council shall consist of nine members elected for terms of three years each, one from each Association District. The judicial powers of the Association shall be vested in this Council whose decision shall be final. The Council shall have jurisdiction in all questions involving membership in the Association. all controversies arising under the Constitution and these By-Laws, interpretation and application of the Principles of Medical Ethics of the American Medical Association, controversies between two or more component societies of the Association and among members of the Association. The Council shall have appellate jurisdiction in questions and controversies referred to the state Association by appropriate and authorized bodies of component medical societies. Appeals shall be perfected within six months following the date of decision by the constituted authority of the component society. The Council, under these several authorities. may conduct such hearings as may be necessary and after due and legal processes may, by majority opinion. censure. suspend, or expel any member for infraction of the Constitution or these By-Laws.

Section 5. Council on Constitution and By-Laws. The Council on Constitution and By-Laws shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be referred all suggested amendments and changes in the Constitution and By-Laws of the Association for recommendation to the Board of Trustees and House of Delegates.

Section 6. Council on Legislation. The Council on Legislation shall consist of nine members, one from each association district, elected by the House of Delegates for terms of three years each which are so arranged that three members are elected annually. This Council shall analyze proposed legislation, recommending to the Board of Trustees courses of action for securing laws in the interests of public health, scientific medicine, as well as medical practice. It shall study and report the need for new and remedial legislation designed to serve the best interests of the state and nation. This Council shall be responsible to the Board of Trustees.

Section 7. Council on Budget and Finance. The Council on Budget and Finance shall consist of five members elected by the House of Delegates for terms of three years each which are so arranged that not more than two members shall be elected annually. This Council shall receive reports of the finances of the Association and to it shall be referred all matters pertaining to the annual budget. The Council shall report annually to the House of Delegates, making specific recommendations on the annual budget of the Association. This Council shall be responsible to the Board of Trustees.

Section 8. Editorial Council. The Editorial Council shall consist of the Editor and the Associate Editors, elected by the House of Delegates to serve two years, and the former shall serve as chairman. To this Council shall be referred all reports of scientific subjects and all scientific papers and discussions presented before the Association and its component societies. The Council shall consider for publication in the official organ of the Association such papers, reports, and other data as may serve to further and advance scientific medicine in Mississippi. It shall exercise editorial authority over the official organ of the Association. This Council shall be responsible to the Board of Trustees.

Section 9. Council on Medical Education. The Council on Medical Education shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be assigned the responsibilities of encouraging undergraduate and postgraduate study of medicine, licensure, and facilities for medical education in the state. This Council shall be responsible to the Board of Trustees.

Chapter X

COMMITTEES OF THE BOARD OF TRUSTEES

Section 1. Committees of the Board of Trustees. Standing committees of the Board of Trustees shall consist of the Advisory Committee to the Medical Auxiliary, Peer Review Committee, the Committee on Publications, and the Committee on Medicine and Religion. All committees of the Board of Trustees shall be appointed by the Board for terms specified unless their selection is otherwise prescribed.

Section 2. Advisory Committee to the Medical Auxiliary. The Advisory Committee to the Medical Auxiliary shall consist of three members appointed for terms of three years each. The committee shall be charged with the responsibility of advising the Woman's Auxiliary to the Mississippi State Medical Association on matters of organization and program activity relating to the supportive role of the Auxiliary in its work with the Association.

Section 3. Peer Review. The Committee on Peer Review shall consist of nine members, one from each Association district, appointed for terms of three years each so as to provide for appointment of three members annually. Members of this committee shall not simultaneously serve on any disciplinary body of the Association or its component medical societies. To this committee shall be assigned the work of peer review, including but not limited to resolution of differences between patient and physician, review of the quality of medical care, adequacy and/or reasonableness of fees, whether due or paid from private or public sources, utilization of health care resources, and liaison with private and public sources of medical care financing. The committee is empowered to encourage a response from any member of the Association in writing or by personal appearance, authority to initiate investigations on its own motion, and authority to file charges against a member in the name of the

committee before the Judicial Council or a disciplinary body of a component medical society. Under no circumstances, however, shall the Committee on Peer Review exercise any disciplinary function nor shall it be empowered to alter the status or standing of any member. The committee shall be empowered to prescribe its rules of operation which shall not be in conflict with the policies or By-Laws of the Association. The committee shall also encourage and assist component medical societies in forming Committees on Peer Review at the local level.

Section 4. Committee on Publications. The Committee on Publications shall consist of six members. These shall consist of the Editor, the two Associate Editors, and three others, the three latter being appointed by the Board of Trustees for terms of three years which are so arranged to provide for appointment of one such member annually. The chairman of the committee shall be designated by the Board. The committee shall implement instructions and policies of the Board of Trustees relating to the official Journal of the Association. Additionally, the committee shall study and recommend to the Board policy proposals relating to organization and production of the Journal, reporting annually its deliberations.

Section 5. Committee on Medicine and Religion. The Committee on Medicine and Religion shall consist of six members appointed for terms of three years each and so arranged to provide for appointment of two members annually. The committee shall be responsible for formulating a program in the field of medicine and religion and for carrying out such assignments as may be made in this connection by the Board of Trustees.

Section 6. Committee on Long-Range Planning. The Committee on Long-Range Planning shall consist of five members appointed for terms of five years each and so arranged to provide for appointment of one member annually. This committee shall receive charges from the Board of Trustees and shall assess developments and requirements in fields of association activity, making recommendations for courses of action to achieve maximum possible effectiveness in all fields of association activity.

Chapter XI
RULES AND CONDUCT

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Chapter XII
COMPONENT SOCIETIES

Section 1. Component Societies. All component societies now in affiliation with this Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Board of Trustees and approval by the House of Delegates, receive a charter from and become a component part of this Association. The Board of Trustees and House of Delegates, on recommendation by the Judicial Council, shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

Section 2. Number of Societies. Only one component medical society shall be chartered in any county but nothing in this section shall be construed as to prohibit unofficial organization of medical clubs or other county level groups of physicians whose purpose it is to further and advance scientific medicine and postgraduate medical education.

Section 3. Members of Societies. Each component society shall judge the qualifications of its own members, but as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who is qualified under Chapter I, Section 1, of these By-Laws shall be eligible for election to membership. Before a charter is issued to any component society, full and ample opportunity shall be given to every such physician in the county to become a member.

Section 4. Right of Appeal. Any physician who may feel aggrieved by the action of the society of his county or District in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Judicial Council, which, upon a majority vote, may permit him to petition for membership in an adjacent society.

Section 5. Evidence of Appeals. In hearing appeals, the Judicial Council may admit oral or written evidence, as in its judgment will best and most fairly present the facts, but in case of every appeal, efforts at a conciliation and compromise shall precede all such hearings.

Section 6. Area Jurisdiction. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Section 7. Professional Authority. Each component society shall have general direction of the affairs of the profession in its jurisdiction and shall constantly use its influence to the moral and professional betterment of its physicians, to the end that the membership shall embrace every qualified physician in its jurisdiction.

Section 8. Meetings. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall especially be encouraged to do postgraduate work, and to give the society first benefit of such labors. Official positions and other preferments shall be unstintingly given to such members.

Section 9. Delegates. Each county shall be entitled to representation in the House of Delegates of this Association, one delegate for each fifty members or fraction thereof. Delegates shall be elected for terms of not less than two years and societies shall report such elections to the Executive Secretary of the Association in no event later than thirty days before the annual session.

Section 10. Duties of Component Society Secretaries. The secretary of each component medical society shall perform such duties as are usual and customary to his office. He shall maintain the official roll of membership for his society, shall collect dues and assessments, and shall make official reports as elsewhere prescribed in these By-Laws to the Association, transmitting dues in behalf of component society members. He shall conduct the official correspondence of his component medical society.

Chapter XIII
FISCAL YEAR

The fiscal year of the Association and its component county societies shall begin January 1 each year and end on December 31 following, but membership in the state Association shall not lapse until April 1 of that year.

Chapter XIV
AMENDMENTS

These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, after the amendment has laid upon the table for one day.

Chapter XV
REPEALING AUTHORITY

Upon adoption of these By-Laws, all previous By-Laws, motions of record, mandates, policies, rules and regulations in conflict therewith are hereby repealed, except that officers elected to serve in the Association and its component societies shall continue their incumbency until the completion of their previously prescribed terms and their successors elected under the current By-Laws.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Nov. 28-Dec. 1, 1971, New Orleans, Annual Convention, June 18-22, 1972, San Francisco. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

AMA Congress on Occupational Health, 31st Annual Congress, Aug. 29-30, 1971, Grand Teton National Park, Wyoming. Louis R. Skiera, Assistant Director, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

STATE AND LOCAL

Mississippi State Medical Association, 104th Annual Session, May 8-11, 1972, Biloxi. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Joel L. Alvis, 714 N. State St., Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Second Wednesday, April and First Wednesday, November, 2:00 p.m., Clarksdale. Glenn L. Wegener, 1967 Hospital Drive, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. John G. Downer, 110 Tchula St., Lexington, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. A. Robert Dill, 1001 Main Street, Columbus, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Robert Donald, Box 1351, Pascagoula, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie Street, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday, January, April, July, and October, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.

Radiologic Seminar CIX
Synovial Sarcoma in the Lower Extremity

CHARLES A. RAY, III, M.D.
Jackson, Mississippi

CASE PRESENTATION: A 61-year-old Caucasian male was seen at UMC with the complaint of pain and a mass in the right leg of several months duration. The mass had been present for approximately 13 years, enlarging slowly and painlessly until about 12 months prior to admission at which time it began to grow rapidly. Ten pounds had been lost in the previous 12 months. On examination a large, firm, non-mobile, minimally tender mass was noted in the proximal leg extending posteriorly and medially. Moderate brawny edema of the leg distally was present. No bruits were heard in the popliteal space or over the tumor mass, and no regional nodes were palpable. The remainder of the physical examination was normal.

Radiographic examination of the lower leg revealed a large soft tissue mass involving the upper third of the right leg. (See Figure 1) There was cortical erosion and disruption of the proximal tibia, and laminograms revealed some mottled areas of radiolucency in the medullary cavity and irregular areas of soft tissue calcification in the mass. (See Figure 2) Chest radiographs revealed two rounded densities suggestive of metastatic pulmonary neoplasm.

A femoral arteriogram (see Figure 3(a), (b)) demonstrated a very vascular neoplasm being supplied primarily from the posterior tibial artery and a large vessel arising from the anterior tibial artery. Many tumor vessels were evident with A-V shunting and prominent vascular pooling. Early filling of both superficial and deep venous systems suggested invasion of the deep veins, and the tumor appears to extend into the tibia.

Biopsy revealed a vascular grayish-white mass and the pathology report was synovial sarcoma. Extension of the tumor into vascular spaces was noted.

DISCUSSION

Synovial sarcoma is a highly specialized and

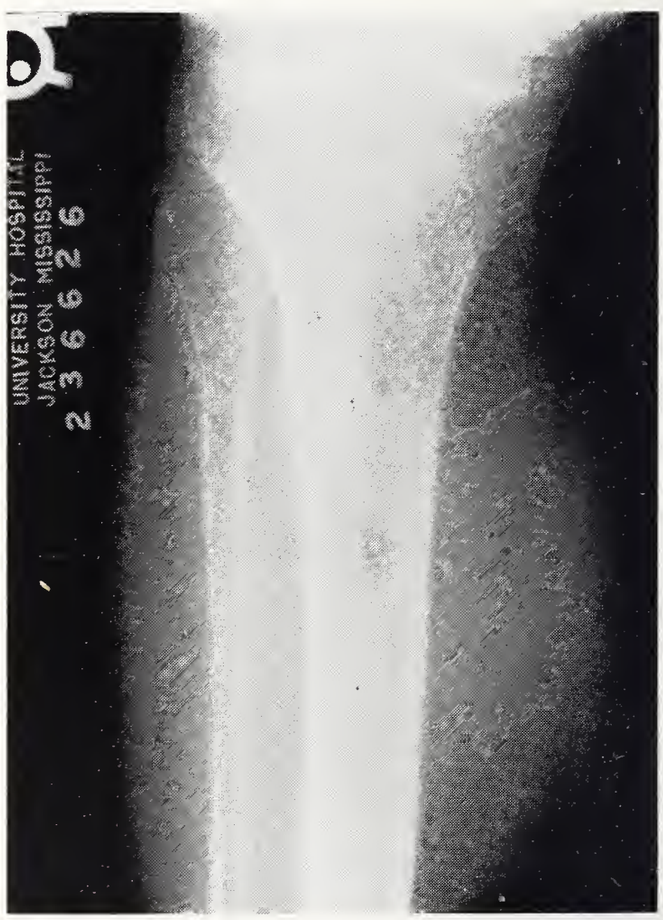


Figure 1. AP view of leg showing large soft tissue mass.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Hospital.

rare form of malignant tumor usually arising from the soft tissues of the extremities, but occasionally in remote areas of the torso, neck and nasopharynx. The lower extremity is involved in about one-half of the cases with the knee being the most common site. Actually, these tumors are not thought to arise directly from the synovial membranes, but rather from immediately adjacent tissues. The synovial membranes may, however, be involved by direct extension. Microscopically, these tumors are composed of two histologically different tissue types, a synovioblastic element plus fibroblastic cells intermingled among the synovioblastic cells.



Figure 2. Laminogram of leg demonstrating mottled areas of radiolucency and irregular calcification in the mass.



Figure 3. (a). Arteriogram. Arterial phase demonstrating many tumor vessels, A-V shunting and vascular pooling. Prominent early draining veins (arrows) suggest direct venous invasion.

Synovial sarcomas are classified as tumors of relatively slow growth, with a reported mean duration from onset to death of five to seven years. Metastasis occurs most commonly in the lungs with nodal involvement next in frequency.

There are no radiological features which distinguish synovial sarcoma from other soft tissue tumors. In large tumors small foci of calcification may be detected, especially at the periphery of the tumor. Angiographically, it may show the characteristic increased vascularity, early venous shunting, tumor vessels and venous pooling seen in

other malignant soft tissue tumors. Very early lesions may be relatively avascular.

Successful treatment necessitates complete local removal before metastasis has taken place. This has been accomplished by both local excision and amputation. Radiotherapy alone has rarely been successful in controlling this tumor, but there is some evidence that combined preoperative irradiation and surgery offer the best chance of cure. The cure rate is in the neighborhood of 25-40 per cent, with a five year survival of approximately 55 per cent. ★★★

2500 North State Street (39216)

REFERENCES

1. Cade, S.: Synovial Sarcoma. J. Roy. Coll. Surg., Edinburgh 8:1-51, 1962.
2. Haagensen, C. D., and Stout, A. P.: Synovial Sarcoma. Ann. Surg. 120:826-842, 1944.
3. Murray, M. R., Stout, A. P., and Pogogeff, I. A.: Synovial Sarcoma and Normal Synovial Tissue Cultivated in Vitro. Ann. Surg. 120:843-851, 1944.
4. Stout, A. P., and Lattes, R.: Tumors of Soft Tissue, in Atlas of Tumor Pathology, 2nd Series. Published by AFIP, 1967, p. 164-171.



Figure 3. (b). Arteriogram. Venous phase.

ELIXIR VITAE

Fred, with mustache bristling and a glass of bourbon in each hand, was overheard saying: "It has been statistically proven that all men who drink plain water eventually die. . . ."

Thank You, Doctor



Your continuing cooperation with the American Association of Medical Assistants has been generous. With your support our organization has achieved a membership of 14,000 medical assistants in more than 400 chapters in 45 states, District of Columbia and Puerto Rico.

Since our first organizational meeting 15 years ago, we have worked toward the primary goal of providing educational opportunities to the medical assistant in the doctor's office. In a short decade and a half the association has:

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- Developed curricula for medical assisting programs in hundreds of junior and community colleges.
- Carried on a continuing education program for medical assistants through seminars, workshops and a professional bi-monthly journal.
- Published career materials and established a scholarship loan fund to help recruit future medical assistants.
- Cooperated with AMA in public relations efforts beneficial to the medical profession as a whole.

But our work cannot stop here. As the only national association for medical assistants, AAMA is eager to contribute to advancement of this allied health field. We would like to share our educational programs with all of the medical assistants across the nation. But to do this we need the co-operation of many more physicians.

If your medical assistant is not a member of AAMA, please fill out this coupon today. Her greater knowledge of medical assisting will be your reward.

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P.S. AAMA bylaws provide that the association, "is not, nor shall it ever become a trade union or collective bargaining agency."



The President Speaking

'Medical Care Foundations'

ARTHUR E. BROWN, M.D.
Columbus, Mississippi

THE 103RD ANNUAL SESSION of the Mississippi State Medical Association is now history. This session was well attended with a larger registration than any of past several years.

This attendance may in part be attributed to the new environment furnished by the new Sheraton-Biloxi. But it is to be hoped that it was also due to an increasing desire on the part of the members to keep abreast of the latest scientific advances and also to learn of the many proposed socio-economic changes. The meetings were well attended, the reference committees were very active and debate was interesting.

One of the debated issues was the matter of the medical care foundation. Both the Council of Medical Service and the Board of Trustees had conducted long investigation of these organizations in other states and they decided we should move into this field. The Board recommended to the House of Delegates that they be authorized and empowered to establish such an organization. There was a great deal of debate on this matter both in the Reference Committee and in the House of Delegates. It is felt that it was not so much a matter of opposition but a lack of knowledge that prompted most of the debate.

The recommendation was approved and the wheels are already in motion to set up the Foundation. This seems to be the last chance to salvage some form of control over the private practice of medicine. There is nothing compulsory as far as physician participation is concerned. Each physician can study the plan and be free to make up his own mind. This is a privilege that may not be his with other proposed methods of delivery of medical care. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 7
JULY 1971

EDITORIALS

The Sexually-Involved Adolescent and Medical Practice Policy

I

THE SEXUALLY-INVOLVED adolescent is a source of deep concern to American physicians. This yet-to-mature individual, while short of being a medical phenomenon, seems to present a unique set of medical problems. Included in this category are the school-age pregnant girl, teenage parents, and the child of these youngsters. Just last week, the American Medical Association, meeting at Atlantic City, debated the issue at length. The views expressed differed, but the depth of concern was common.

The statistics on teenage marriage are discouraging. In 1967, the most recent year for which the data are anywhere near complete, 197,000 American girls under age 18 gave birth to a child. Of these, 78,000 were unmarried. We do know that the rate of increase among these adolescent mothers has been at least 2 per cent or 4,000 births annually.

The dismal figures do not take into account premarital pregnancy forcing early marriage or the frequency of abortion—legal or illicit—since the data cover only live and recorded births. The AMA Committee on Maternal and Child Care says that as many as 48 per cent of teenage marriages involve a premarital pregnancy. Court records everywhere tell us that half of these marriages end in divorce within four years.

Couple to this unfortunate state of human affairs the rising rate of venereal disease among youngsters which is now being called pandemic in many responsible quarters. It all adds up to a question demanding the best answer which a concerned society can produce. If all of this were hardly a fit subject for discussion a few years ago, then it is time we brushed aside taboo parameters of parlor conversation and got to the heart of the problem. The implications are too serious, and the consequences of the trend unchecked are fearful to contemplate. This is exactly why the AMA should be applauded for meeting the issue head on.

II

Apart from moral considerations in furnishing contraception advice and prescriptions to unmarried teenage girls, there is the liability potential. The issue is not so much a cloudy one as it is a vacuum. The Office of the AMA General Counsel, probably the most capable medicolegal research organization in the nation, has been unable to find a single court decision holding a physician civilly or criminally liable for provid-

ing contraceptive information and services to a minor, married or unmarried.

But only one state, Illinois, has acted affirmatively to clear the issue. Its legislature passed the Birth Control Services to Minors Act last year, permitting physicians to supply contraception information and services to any minor who is either married, a parent, pregnant, has the consent of his or her parent or legal guardian, for whom failure to supply such services would constitute a serious health hazard, or who is referred for such services by another physician, clergyman, or planned parenthood agency.

There is a logical and consequently popular belief among many physicians that the possibility of liability in this area is remote. They prescribe contraceptives for unmarried minors with their individual best medical judgment and professional discretion. But they may be practicing on the basis of an unwarranted legal assumption made all the more real by the lack of statutory and case law.

In the absence of statutory protection or clear and unmistakable judicial precedents protecting the physician, the element of uncertainty in the law should be recognized. We hardly need the lawyers to remind us that the courts in the various states react quite differently to identical fact situations.

The consensus of conservative medicolegal opinion is that physicians prescribing contraceptive devices and agents for unmarried minors are well-advised to follow these minimum criteria for what is obviously minimum protection:

—They should inquire as to the feasibility or possibility of obtaining consent for the services from the teenage patient's parents or guardian.

—The total situation of the patient should be considered and a full case history obtained and recorded.

—Where an "emergency" appears to exist, the medical record should reflect the basis for the physician's judgment that pregnancy would constitute a more serious health hazard than birth control measures prescribed.

—The minor should be required to sign a consent form indicating clear understanding of the problem and the nature and consequences of the contraception recommendations or prescription. While this is of questionable legal value as a stonewall defense, the attorneys advise it.

—The physician should insist upon follow-up care where indicated.

III

Three major national specialty societies, the American Academy of General Practice, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists, have adopted policy positions on this crucial issue. Generally, the policies have been based on the premise of reducing teenage pregnancy as a goal consistent with responsible preventive medicine.

In general, these societies state that the teenage girl whose sexual behavior exposes her to possible conception should have access to medical consultation and the most effective contraception advice and methods consistent with her physical and emotional needs.

They contend that the physician so consulted should be free to prescribe or withhold contraceptive advice in accordance with his best medical judgment in the interests of his patient.

Obviously, this policy area must be recognized as delicate, because many will wish to read into it an aspect of permissiveness arising out of the rendering of the professional services. It should be noted, however, by those most sincerely and conscientiously opposed to the policy on moral grounds that the circumstances pre-exist the physi-



"You're in great shape, but your wooden leg has the Dutch Elm Disease."

cian's making his decision to prescribe or not prescribe.

Those who support the policy are considering the medical aspects of teenage pregnancy where, in or out of marriage, many serious medical, psychological, social, and educational problems are almost automatically created. Compounding this is the tragedy of the unwanted child by the teenage parents—or more often, by the teenage mother alone.

The AMA committee statement says that "for mother and child, teenage pregnancy is often the critical initiating factor and later a continuing major contributory factor in the development of psychosomatic, psychoneurotic, and even occasional psychotic illnesses."

IV

This then is one of the difficult issues with which medicine has to grapple. Ironically, it is not a disease entity for which no successful treatment exists or where the etiology is unknown. As summarized in debate recently, it is not a matter of can it be done but rather shall it be done.

It is an issue with compelling medical problems which are really not too debatable in the light of extensive evidence. Yet, it is interwoven with moral facets which generate sincere regret that it is a problem at all.

Then there is the legal aspect which is of concern to medical associations working to protect the interests of ethical practitioners and to assure the delivery of sound, timely care and services. As with the emotion-charged issue of abortion a few short years ago, the state of the science is far ahead of the mores of society and the laws of the land.

In this discussion where genuine effort was made to refrain from advocacy, there is a medical issue of major proportion which American medicine is considering. In the context of individual professional responsibility and the freedom to exercise the best medical judgment, each physician must ultimately make these decisions for himself, and his medical association should assure and defend this prerogative of the practitioner.

Medicine did not create the problem, nor will it likely solve it singlehanded. But it will discuss it, study it, and eventually act on it with the degree of responsibility, concern, and compassion which makes medicine the noble calling it is.—R.B.K.

Public Health Is Under Attack

Mounting attacks on state departments of public health are disquieting to the medical profession and a matter of deep and continuing concern. Sources of the onslaughts vary, but more frequently than not, these involve other agencies of government and allied health professional groups and organizations who want a piece of the action, and consumers.

Reduced to the least common denominator, public health is one of the 20 specialties in medicine, specifically preventive medicine. Simply because its practitioners and their associates are within the structure of government does not alter their role and responsibility for a specialized medical service.

It was once written of the late Dr. Felix J. Underwood, our state health officer for nearly four decades, that "he saved a million lives" in Mississippi, and that's probably an understatement. This brilliant leader, whose name stands as legend in preventive medicine, was about as medically oriented as one can be. He was a doctor's doctor and made no bones about it.

Were Dr. Underwood with us today, he would doubtless be much more concerned than we are about erosion of public health authorities and functions and the move toward consumer-oriented, diluted boards of health.

In neighboring Alabama, there is a unique legal structure for the State Board of Health. Under the laws of 1873, the Medical Association of the State of Alabama *is* the State Board of Health, and every member of the medical association is a member of the board. The medical association's governing board exercises the functions of the Board of Health, accountable to their peers and state government.

The structure is now under attack, according to Alabama association publications, as various groups, both professional and allied health organizations, are said to have mounted vigorous programs to change the law and the makeup of the board.

During the 1971 Regular Session of the Mississippi Legislature, there were 21 bills introduced to make similar changes in the Mississippi State Board of Health. The common thread running through these proposals invariably sought two goals: To dilute the present Board of Health with new disciplines, some pretty remote from medicine, and to divest the Board of the medical li-

censure function. One bill would have abolished the present Board, substituting an 11-member body with only one physician on it.

At national level, the American Public Health Association is not always in agreement with the views of clinicians, but there is usually a viable partnership at state and local level between private practitioners and those in preventive medicine. This partnership has been a source of pride and satisfaction among Mississippi physicians for nearly 100 years. The association nominates eight of the 11 members of our Board, and the State Health Officer, always a physician, is elected by the Board itself.

Let us be sensitive and alert to this apparent trend which has characteristics of being another aspect of the continuing attack upon the American health care and delivery system. Let us reinforce the bonds that logically and historically unite public health with private practice and maintain medical leadership for medical functions of government in behalf of all citizens.—R.B.K.

Medicare, Medicaid and Texas-Rich M.D.'s

There was no teapot big enough to hold the tempest stirred up over the headline-hunting antics of the Senate Finance Committee staff a year ago when the word went out that American physicians were getting Texas-rich off Medicare and Medicaid. As was noted hereabouts, the senate committee staff just hadn't filed claims for such services in Mississippi which, at current professional reimbursement levels, more nearly resemble a poverty program.

But the blast was let loose, the bleeding hearts in the mass media, on the floors of legislative assemblies, and a few groups not exactly noted for a lack of self-interest lowered the boom on the practicing physician. Forthwith, the orders went out that any practitioner who received $25,000 or more during 1968 under Medicare and Medicaid should get the full treatment by the Internal Revenue Service. It is reliably estimated that the IRS investigations involved only slightly more than 8,000 practitioners, not all of whom are physicians.

Now the investigations are concluded, and the figures are in—very much on the side of the "accused." But there are no headlines, no hoopdela, and no big news conferences by the sources of the original blasts.

IRS says that 83 per cent of all physicians, dentists, osteopaths, and others investigated had reported their receipts correctly and that their claims for services were in good and legal order. Of those who erred, 15 per cent had underreported receipts but by an average of $7,700, while 2 per cent had overreported receipts by an average of $16,000, making for quite a nice refund.

Overall, IRS said, 99 per cent of actual receipts and 97 per cent of net earnings were correctly and accurately reported. Only 47 cases were referred for further investigation.

There is even more in what is not stated in the IRS release, because the nature of professional fee payment under Medicare and Medicaid is a little different from selling a loaf of bread. There are complex credits and disallowances, occasional overpayment goofs with subsequent and vexing recoupment procedures, misplaced claims, misdirected checks, and a host of improbable procedures making bookkeeping in a doctor's office something less than a nightmare and more than a mildly traumatic experience.

Let the issue be put at rest as another political blast which harmed many, served no useful purpose, cast a shadow over the innocent, and underscored not a failure of probity among physicians and others but the injustice of the whole disgusting episode.—R.B.K.



"Does he know anything about spells?"

Hospital Costs Are up, Up, UP!

If the nation's economy is cooling off and if inflation is showing some signs of subsiding, it has yet to spill over into hospital costs. On August 1, the American Hospital Association will drop its annual blockbuster on this sensitive and upward moving cost segment of health care delivery.

The cost of providing care for one hospital patient for one day in 1970 was $81.01, says AHA. This, mind you, is a mean, because the figure was derived from simple division of per diem costs for the nation's 5,880 community hospitals into the total tab of $19.6 billion, the country's hospital bill last year.

Actually, this mean is misleading, because cost spreads vary widely throughout the United States among the different types and sizes of hospitals. A significant and large number experience costs of $100 or more per patient day, and the figure is not static.

AHA will say in its announcement that this represents an increase of 15.7 per cent over 1969 which is typical of the large and uncomfortable rate of growth for hospital costs for more than three years. Overall, the institutions' price rise has aggregated more than 425 per cent since the end of World War II.

Just about everybody understands that people are the crucial quantity in the hospital cost equation. From the smallest to the largest hospital, from 66 to 70 cents of every hospital dollar available must go for salaries and wages. The economists tell us that the hospital is a "wage-burdened" institution, a characteristic of service organizations. In contrast, the typical manufacturing industry lays out 25 to 30 per cent for wages with the big expenditures in raw materials, manufacturing processes, and distribution.

Dr. Edwin L. Crosby, AHA president, notes that "the inflationary spiral of the nation's economy has played a large part in the rise of hospital costs. Everything hospitals buy costs more than a year ago, and salaries and wages continue to increase."

Underscoring the wage-burdened circumstances, AHA points out that hospital payrolls in the U. S. rose to $11.4 billion in 1970 from $9.8 billion in 1969, a jump of 16.4 per cent.

The size of the hospital payroll grows, too, because AHA records 2.5 million employees in hospitals last year for a new high of 292 employees per 100 patients. Yet the occupancy rate has dropped slightly, being down about 1 per cent to 78 as a national mean in 1970. But the length of stay decreased one-tenth of a day, and however small it is, this is helpful.

The plight of the nation's hospitals in cost rises demands fullest application of management skills, innovation where practical for achieving economies, and full support of peer review by practicing physicians.—R.B.K.

Up the Communications With AMA Update

The *AMA News,* since renamed the *American Medical News,* was born about 13 years ago as a popular communications medium. Begun as a house organ, the publication has evolved into a semi-independent tabloid eager to treat controversial issues in medicine, almost as if it were apart from its publisher, the American Medical Association. The mailing list of the *News* is impressive, because it goes to every American physician and just about every opinion leader whose name can be garnered for the subscription list.

Now there is another one, this time a bulletin format called *AMA Update.* It will undertake communication of AMA views to the Congress, executive agencies of government, and opinion leaders. Candid but basically softsell, *Update* seems to strive for informality, credibility, and pertinence.

A second issue compares lobbying expenses, showing AMA to be 14th among the top 15 lobbying organizations in the United States. It talks about the physician shortage, frankly stating that the situation isn't likely to be better soon. After a folksy story or two for general reader interest, it gets to the nitty-gritty of health care delivery in rural areas.

Update is modest in format, although done with the professionalism expected of AMA. It obviously is not a high budget enterprise, and if successful, it would have well-justified its editorial, production, and distribution costs.

The intriguing thing about the communications phenomenon is proliferation. Twenty years ago with the crisis of compulsory national health insurance under the fading Truman administration with the introduction of the Wagner-Murray-Dingell bill, we fretted and fussed over communication challenges in getting to the practicing physician. Two decades and literally dozens of media, printed, taped, visual, and what have you, we are still concerned with communication.

It is a field with many experts, and nearly every one of them has a new medium to suggest as

a remedy, if not a panacea. We wish *Update* well as it joins the tonnage of the printed word for, about, and to American medicine. May it help shore up the gap which we all know is there. —R.B.K.

PERSONALS

TEMPLE AINSWORTH of Jackson has been presented a special award for meritorious service by the Mississippi Kidney Foundation. Dr. Ainsworth is now serving as president of the American Urological Association.

JULIUS BOSCO, NICHOLAS DISANTI, and GEORGE HENNEBERGER of Ocean Springs announce the opening of their office for the practice of obstetrics and gynecology in FRANK O. SCHMIDT's former office. Dr. Schmidt has retired.

RUFUS M. BROWN, formerly of Pontotoc, has been appointed to the staff of the Northeast Mississippi Hospital at Booneville. Dr. Brown recently finished a residency in surgery at St. Joseph Hospital in Memphis.

E. DUANE BURGESS of Hattiesburg announces the association of G. O. RUNNELS in the practice of psychiatry in the Medical Arts Building, 405 S. 28th Avenue.

WILFRED Q. COLE and GEORGE C. HAMILTON of Jackson participated in the recent Southern Lawn Tennis Association's championship tournament at the River Hills Club in Jackson.

The yard of the HENRY W. DEWITTS of Laurel was chosen as winner of the Yard of the Month Club for the month of May.

Margaret Ellis Rogers, daughter of DAVID B. ELLIS of New Albany, was presented the 1971 Taylor Medal in accounting for outstanding academic achievement in annual Honors Day ceremonies at Ole Miss.

JAMES GORDON of Tupelo reviewed "The Making of a Surgeon" by William A. Nolen, M.D., on the Lee County Library program sponsored by radio station WELO.

J. S. HARRISON, formerly of Bruce, accepted a position as staff physician with the East Mississippi State Hospital in Meridian, effective June 1.

VERNER HOLMES and LEWIS J. RUTLEDGE of McComb announce the removal of their Brookhaven office in the Brookway Plaza Shopping Center to the Professional Building at the corner of West Court and North Church Street.

W. B. HUNT of Grenada has been certified as a Diplomate of the American Board of Family Practice.

JOHN R. JACKSON, JR., of Hattiesburg and SUZANNE T. MILLER of Jackson have been elected Fellows in the American Academy of Pediatrics.

WILLIAM A. LONG, JR., of Jackson has been presented the 1971 Liberty Bell Award for outstanding community service by the Hinds County Bar Association and Jackson Junior Bar Association. The adolescent medicine specialist was cited for his work with young people and his efforts which led to the establishment of Youth Crisis Centers, Inc.

ROBERT D. MCBROOM of Pascagoula announces the association of LARRY M. MITCHELL for the practice of internal medicine and gastroenterology at 3102 Pascagoula Street.

ROBERT L. MCKINLEY of Tupelo presented a workshop entitled "Physec" at the 5th annual convention of the Mississippi Chapter of the American Association of Medical Assistants in Tupelo.

ROBERT H. MIDDLETON, JR., of Biloxi, PAUL E. EDWARDS, JR., of Columbus, MARION V. GREEN of Holly Springs, JOHN LEVENS of Bay St. Louis, LAWRENCE H. BRISCO of Tupelo, W. F. STRINGER of Poplarville, CHARLES P. BASS and THOMAS B. WHITEHEAD of Columbia, W. MONCURE DABNEY and L. D. TURNER of Crystal Springs have been re-elected to active membership in the American Academy of General Practice upon completion of 150 hours of postgraduate study during the last three years.

WILLIAM H. ROSENBLATT, JAMES C. HAYS, and JAMES L. CROSTHWAIT of Jackson announce the formation of the Jackson Heart Clinic at 615 Medical Arts Building.

LOUIS A. RUBENSTEIN of Ocean Springs announces the association of BEN E. KITCHENS in the practice of family medicine at Spring Plaza Shopping Center.

ROBERT E. SCHWARTZ of Hattiesburg, GUY C. CAMPBELL, JOHN F. BUSEY, ROLAND B. ROBERTSON, HELEN C. BERNFIELD, all of Jackson, and JOHN WILLIAMS of Greenville attended the joint annual meeting of the National Tuberculosis and

Respiratory Disease Association and its medical section, the American Thoracic Society, in Los Angeles recently.

Eugene Carroll Stone of Oxford announces the removal of his offices from 613 South Lamar to 2166 South Lamar.

Virginia S. Tolbert of Ruleville has been re-elected president of the Sunflower County Heart Association and Walter H. Rose of Indianola will again serve as Heart Fund Chairman.

R. E. Ward, Jr., announces the opening of his office for the practice of family medicine at Clinton Plaza Shopping Center in Clinton.

Reginald P. White of Meridian has been elected 1971-72 president of the Meridian Rotary Club.

William B. Wilson and Francis S. Morrison of Jackson have been initiated as new Fellows of the American College of Physicians.

W. Johnson Witt of Jackson has been elected president-elect of the Mississippi Diabetes Association. Elected to the Board of Directors were Karleen Neill, Herbert G. Langford, Perrin H. Berry, L. Tate Carl, W. J. Huddleston, S. H. McDonnieal, Jr., C. E. Wallace, Eric McVey, and W. F. Sistrunk, all of Jackson.

William M. Wood of Meridian participated in a panel discussion at a special seminar on social needs of hospital patients sponsored by the Mississippi Hospital Association in Jackson recently.

NEW MEMBERS

Brann, Alfred Willard, Jr., Jackson. Born Pine Bluff, Ark., June 13, 1934; M.D., Tulane University School of Medicine, New Orleans, La., 1960; interned Vanderbilt University Hosp., Nashville, Tenn., one year; pediatric residency, same, July 1, 1961-June 30, 1963; member, Sloan Kettering Cancer Center, July 1, 1963-June 30, 1964; neurology residency, University Virginia Hospital, July 1, 1964-June 30, 1965; residency in Neuropathology, same, July 1, 1965-June 30, 1966; pediatric neurology residency, Massachusetts General Hosp., Boston, Mass., July 1, 1965-June 30, 1966; elected by Central Medical Society in Nov., 1970.

Carlson, David Ivan, Jackson. Born Bessemer, Pa., Sept. 24, 1937; M.D., University of Mis-

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sissippi School of Medicine, Jackson, Miss., 1962; interned John Sealy (Univ. of Texas Medical Branch), Galveston, Texas, one year; surgery residency, UMC, Jackson, Miss., July 1, 1963-March 31, 1965; anesthesiology residency, same, July 1, 1968-June 30, 1970; elected in Nov., 1970 by Central Medical Society.

DOWNER, JOHN GELSTON, Lexington. Born Lexington, Miss., Dec. 19, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned, same, one year; elected in May, 1971 by North Central District Medical Society.

HORTON, THOMAS HOMER, Tupelo. Born Grenada, Miss., Oct. 24, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned, same, one year; anesthesiology residency, same, July 1, 1968-June 30, 1970; elected in March, 1971 by Northeast Mississippi Medical Society.

JONES, H. READ, Tupelo. Born Tupelo, Miss., Nov. 25, 1934; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1961; interned Methodist Hospital, Memphis, Tenn., one year; anesthesiology residency, UMC, Jackson, Miss., Aug. 15, 1967-Aug. 15, 1969; elected in March, 1971 by Northeast Mississippi Medical Society.

LIPSCOMB, LEWIS DUBARD, Jackson. Born Jackson, Miss., Oct. 30, 1937; M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1964; interned, UMC, Jackson, Miss., one year; obgyn residency, same, July 1, 1965-June 30, 1968; elected in March, 1971 by Central Medical Society.

NORMAN, JOE ROBERT, Jackson. Born Birmingham, Ala., March 10, 1928; M.D., Medical College of Alabama, Birmingham, Ala., 1957; interned, same, one year; internal medicine residency, same, July, 1958-June, 1960, July, 1961-June, 1962; elected in March, 1971 by Central Medical Society.

THOMPSON, ROBERT HARVEY, JR., Jackson. Born Jackson, Miss., Feb. 6, 1939; M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1965; interned, same, one year; pediatric residency, Babies Hospital of New York, N. Y., July 1, 1966-June 30, 1968; elected in Nov., 1970 by Central Medical Society.

DEATHS

DUMAS, ALBERT WOODS, JR., Jackson. M.D., Howard University College of Medicine, Washington, D. C., 1931; interned Freeman's Hospital, Washington, D. C., one year; died May 7, 1971, age 68.

FIELD, RICHARD JENNINGS, SR., Centreville. M.D., Tulane University School of Medicine, New Orleans, La., 1920; interned Touro Infirmary, New Orleans, La., one year; residency, surgery, Touro Infirmary, New Orleans, La., one year; president, Mississippi Hospital Assn., 1933; president, Wilkinson County Medical Society, 1952-53; president, Amite-Wilkinson Medical Society, 1954-55; member of Fifty Year Club of MSMA; Emeritus member of MSMA & AMA; died May 19, 1971, age 75.

GUYTON, BILLY SYLVESTER, Oxford. M.D., University of Virginia Medical School, Charlottesville, Va., 1913; interned Martha Jefferson Sanatorium, Charlottesville, Va., one year; interned Orange Memorial Hospital, N. J., one year; past-president, Louisiana & Mississippi O&O; president, MSMA, 1950-51; Dean, University of Mississippi Medical School, 1935; member of Fifty Year Club of MSMA; died May 16, 1971, age 87.

SEARCY, R. T., Cleveland. M.D., Meharry Medical College School of Medicine, Nashville, Tenn., 1950; interned Hubbard Hospital, Nashville, Tenn., one year; died May 24, 1971, age 52.

MSMA Has New P.O. Box Number

The post office box number of the state medical association has been changed from 4606 to 5207, effective July 1, according to Rowland B. Kennedy, executive secretary.

Full address of the association is now P. O. Box 5207, Jackson, Mississippi 39216. The headquarters office building is located at 735 Riverside Drive.

Book Review

Handbook of Pediatrics, Ninth Edition. By Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D. 713 pages. Los Altos, California: Lange Medical Publications, 1971. $6.50.

This is a well-tried pediatric classic that is being continually updated for use by the medical student, the intern, and the pediatric resident, as well as the active practitioner who engages in any of the varied ramifications of this specialty. "Practical notes" in the physical exam outline offers good points and advice obviously derived from long experience. Although the general comments are good regarding management during illnesses, it is regrettable to see the unsupportable recommendation of four times the normal dose of Vitamins A, B, C, and D being advocated during convalescence. There seems to be no value in listing the weights of the various organs of the body from the fetus to the adult.

There is an up-to-date discussion on the following which appear to be exceptionally well handled: developmental screening; antimicrobial agents; physiological changes in the newborn; important differences between the premie and the low birth weight term newborn; problems peculiar to the adolescent; dermatological preparations and their indications; croup; nephritis and nephrosis; and Diabetes Mellitus.

The chapter on emergencies and the one on poisoning present many practical, well-organized methods of approach to specific problems. There is a good description of an extremely useful and relatively new procedure, suprapubic percutaneous bladder aspiration.

The appendix contains, along with the usual index, charts, and graphs, a useful complete listing of frequently used drugs with recommended doses, normal lab values with age variations, an informative list and description of chromosomal disorders, and a useful differential diagnosis list for the more common diagnostic problems according to symptoms and signs.

In all this book is impressive in its brevity, its current application, its practical suggestions, and its organization. The latter makes this a very easy book to use.

JOHN R. JACKSON, JR., M.D.

New Books Received

Healers in Uniform. By Edward Edelson. 184 pages. Garden City, N. Y.: Doubleday and Company, Inc., 1971. $3.95.

Textbook of Medical Physiology. By Arthur C. Guyton, M.D. 1032 pages with 757 illustrations. Philadelphia: W. B. Saunders Company, 1971. $18.50.

Handbook of Pediatrics. 9th Edition. By Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D. 713 pages. Los Altos, Calif.: Lange Medical Publications, 1971. $6.50.

Basic Human Physiology: Normal Function and Mechanisms of Disease. By Arthur C. Guyton, M.D. 721 pages with illustrations. Philadelphia: W. B. Saunders Company, 1971. $12.75.

Handbook of Obstetrics and Gynecology. 4th Edition. By Ralph C. Benson, M.D. 774 pages with illustrations. Los Altos, Calif.: Lange Medical Publications, 1971. $6.50.

Dr. Rawson Gets SMA Research Grant

The research project of Dr. John E. Rawson of Jackson, fellow in pediatrics at the University of Mississippi School of Medicine, has won a financial award from Southern Medical Association in the form of a Research Project Fund grant.

Dr. Rawson was one of 21 physicians and medical students chosen from throughout SMA's 16-state southern area to receive a research grant this year. The grants are conferred annually for the purpose of beginning a research project or continuing a relatively new project.

The subject of Dr. Rawson's research project is regional cerebral blood flow in newborn Beagles measured by hydrogen clearance.

In keeping with its primary objective to develop and foster scientific medicine, SMA established the Research Project Fund in 1969.

Headquartered in Birmingham, Ala., SMA is comprised of more than 20,000 physicians from throughout the South and the District of Columbia. The 65th Annual Meeting, an expansive session of scientific exhibits and seminars, will be held this year in Miami Beach, Nov. 1-4.

AAGP Will Meet in Miami Beach

The American Academy of General Practice's top postgraduate event of the year, the Annual Scientific Assembly, will be held this year at the Convention Hall in Miami Beach, Fla., Oct. 4-7.

The program will be led off by Robert Young, television's "Marcus Welby, M.D.," who will keynote the meeting by relating his experiences in learning about the importance of family medicine through his participation in the television role. The award-winning television series is endorsed by the Academy.

Following Mr. Young will be a multimedia mixture of vital medical subjects from top professionals in all areas of medicine. Included will be: "Mental Health and the Physician," by Dr. Roy W. Menninger of the Menninger Foundation, Topeka, Kas.; "The Psychology of Dying," by Dr. Elizabeth K. Ross, Flossmoor, Ill.; "Current Treatment of Infertility," by Dr. Robert B. Greenblatt, Medical College of Georgia; and "Surgical Treatment of Advanced Heart Disease: Repair and Replacement," by Dr. Denton A. Cooley, Texas Heart Institute, Houston.

An added attraction will be a premier presentation of a "Marcus Welby, M.D." episode, that will be shown for the first time anywhere at the Assembly. Presented by Mr. David Victor, executive producer of the series, the preview showing will be held Monday night in the Convention Hall. Mr. Victor has said the episode will deal with family medicine.

The Congress of Delegates will meet Oct. 2-4 at the Fontainebleau. The Delegates' dinner will be held Monday night, Oct. 4, and the President's reception and dance will be Wednesday night, Oct. 6. Inauguration of new officers and directors will immediately precede the President's reception. All social events will be held in the Fontainebleau. A ladies' program, featuring a panel discussion of a current topic by leading female personalities, is being planned.

A tour aboard a cruise ship in the Caribbean will follow the close of the Assembly. One port of call will be St. Thomas, Virgin Islands, where the post-Assembly group will meet with members of the new Virgin Islands chapter. The ship is scheduled to sail Saturday, Oct. 9. Dr. William E. Lotterhos of Jackson, Miss., president, is chairman of the scientific program for the tour.



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Board of Trustees Begins Organizing Mississippi Foundation for Medical Care

Organization of the Mississippi Foundation for Medical Care was begun during a special meeting of the association's Board of Trustees at Jackson June 9-10. Dr. J. T. Davis of Corinth, Board chairman, said that implementation of the program would follow policies approved by the House of Delegates at Biloxi in May.

The foundation will be association-sponsored and physician-controlled, Dr. Davis said. It will, however, have its independent board of directors made up of physicians and be a corporation not for profit under Mississippi law.

The House action in May came after reports of studies by the Board of Trustees, Committee on Peer Review, and Council on Medical Service were submitted to the policy-making body.

Established first in California in the 1950's, medical care foundations have been successful in administering medical care programs, conducting peer review by physicians, and assisting in utilization review.

There are now about 25 medical care foundations in 10 states, Dr. Davis said. In California alone, there are 16 foundations serving 1.5 million patients and 6,000 physicians. Other care foundations are statewide, and all are sponsored by state medical associations.

"The function of the Mississippi Foundation for Medical Care will closely resemble the association's administration of the CHAMPUS program," the Board chairman explained.

"The foundation will be empowered to contract for care plan administration just as we have done for 14 years with the Department of Defense, and it will also conduct peer review and really serve as an advocate of the patient while it stands as a buffer between the physician and the third party financing source," Dr. Davis said.

The Mississippi foundation will have two types of membership, administrative and participating. The House of Delegates designated the Board of Trustees as the administrative members who will have the duty of naming the foundation's board of directors.

Participating members will be those physicians who choose voluntarily to avail themselves of the foundation's services for claims processing and representation to third parties.



Top association officials discuss the new Mississippi Foundation for Medical Care and its extensive peer review program. From the left, Drs. Arthur E. Brown, president; Millard S. Costilow, chairman of the Committee on Peer Review; and Charles R. Jenkins, president-elect.

Dr. Davis stressed that medical care foundations are not unions nor can they affect membership or practice status. They are controlled by their physician-owners who place emphasis on realistic budgeting for health care services on a basis of fairness to patient and physician.

A primary activity of the care foundation is peer or quality care review. Dr. Davis said that this is an educational function for quality improvement.

State medical associations are sponsoring care foundations in Arizona, Colorado, Florida, Georgia, Illinois, Iowa, Minnesota, New Mexico, New

York, and Pennsylvania, in addition to the pioneering and successful organizations in California.

Many administer Medicare and Medicaid in addition to private insurance programs, Dr. Davis said. At least 25 new care foundations are in organization or planning stages in as many states.

Support for the foundation is derived from nominal fees charged for care plan administration and paid by third parties. It will have authority to conclude contracts for such projects, much in the same manner that the CHAMPUS contract has been administered by the association for a decade and a half.

Dr. Davis said that the Board has authorized performance of legal work to draft articles of incorporation and by-laws. All such structures will be within policies voted by the House of Delegates, he added.

It is anticipated that the Board will appoint the foundation's board of directors during the summer, as soon as the corporate charter is issued. The foundation will be nonprofit and tax-exempt.

Dr. Berry Receives SMA Residency Grant

Dr. Don W. Berry, resident in general surgery at University of Mississippi School of Medicine, has been awarded a Residency Training Grant by Southern Medical Association.

Dr. Berry was one of eight physicians selected from throughout SMA's 16-state southern area to receive a residency grant this year. The grants are awarded annually for a 12-month period beginning July 1.

SMA established the grant program in 1962 to assist resident physicians in funding their residency training or additional special education. Recipients must also be engaged in clinical or laboratory research.

The subject of Dr. Berry's research project is septic shock, arterial trauma and perianal suppurative hidradenitis. A graduate of University of Texas Southwestern Medical School, Dr. Berry interned at Parkland Memorial Hospital in Dallas.

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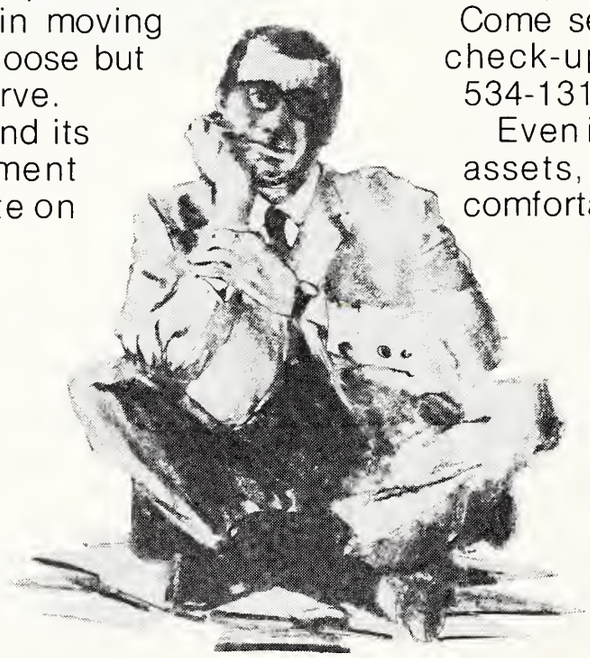
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Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.
Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.
Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.
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MC Gives Dr. Hall Honorary Degree

Dr. Wesley W. Hall of Reno, Nev., president of the American Medical Association and an alumnus of Mississippi College, was one of five prominent men to receive honorary doctorate degrees from the college during its annual commencement.



Dr. Hall

Dr. Hall, who was born in Lumberton, was presented the doctor of science degree in ceremonies at the Jackson City Auditorium.

The AMA leader studied medicine at the University of Mississippi for two years and got his M.D. degree from Tulane University in 1930. He served his internship and surgery residency at the Baroness Erlanger Hospital at Chattanooga.

Dr. Hall represents the fifth generation of medical men in his family, and also has two sons in medicine. After practicing in Shelby for eight years, he moved to Nevada and has practiced there for the past 26 years.

The surgeon is currently senior consultant in surgery, orthopedics and gynecology at Washoe Medical Center and St. Mary's Hospital in Reno. He helped write the legislative proposal that resulted in the establishment of the medical practice act which set up a rigid basic science exam for licensure in Nevada. He was a charter member of the Reno Surgical Society.

Long active in medical organization, Dr. Hall has served the AMA for 24 years either as delegate or member of the Board of Trustees of which he was elected vice-chairman and chairman. He has been secretary and president of the Nevada Medical Society.

Dr. Hall is a past president and the founder of the Reno Executives Club and is a former director of the Reno Chamber of Commerce. In 1970 he was the recipient of the University of Nevada's Distinguished Nevadan Award.

The physician is a York and Scottish Rite Mason, Past Master (Blue Lodge) and medical director of the Kerak Temple of the Shrine.

Dr. Hall spoke to the House of Delegates of the Mississippi State Medical Association at its 100th annual session in 1968 in Jackson.

Expo I Seeks Physician Exhibits

The Mississippi Health Expo I, set for Oct. 1-3 in the Mississippi Coliseum at Jackson, is now accepting applications for exhibits.

Physicians who wish to present personal exhibits are urged to submit applications and a description of the exhibit to the association marked for the attention of the Expo I exhibit committee.

Dr. T. A. Baines of Jackson, chairman of the exhibit committee, asked that the exhibits be oriented for the public education rather than to a professional audience.

The Expo I committee representing the state medical association consists of Drs. C. G. Sutherland, Raymond S. Martin, Jr., Raymond F. Grenfell, and Jim G. Hendrick, all of Jackson.

AMA Attorneys Address MHA Meet



Bernard D. Hirsch, AMA General Counsel, addresses hospital administrators and chiefs of medical staffs at a Mississippi Hospital Association seminar on "The Impact of Law on the Member of the Hospital Staff," held at LeFleur's Convention Center in Jackson. At left is Miss Betty J. Anderson, assistant to the AMA general counsel and a specialist in health service law, and Charles Flynn, MHA executive secretary.

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Board of Trustees Announces Changes

Dr. James L. Royals of Jackson, a past president of the association, has resigned as District 5 Trustee because of professional practice commitments, according to Dr. J. T. Davis of Corinth, Chairman of the Board of Trustees.

Dr. Davis said the resignation was reluctantly accepted "with full understanding of Dr. Royals' circumstances and recognition of his substantial and priceless contributions of leadership in the association." Dr. Royals was elected at the 103rd Annual Session, May 6, 1971 at Biloxi.

Succeeding Dr. Royals is Dr. Carl G. Evers of Jackson, appointed by President Arthur E. Brown of Columbus.

Dr. Evers represents District 5, the largest segment of the membership, including the Central Medical and West Mississippi Medical societies.

The new Trustee is associate professor of pathology at the University of Mississippi School of Medicine and his chief interest is in pathology research.

Dr. Evers received his M.D. degree from the University of Minnesota School of Medicine at Minneapolis, interned and completed his pathology residency at the University of Mississippi Medical Center.

He served as 1970-71 president of the Mississippi Association of Pathologists and is also a member of the International Academy of Pathology, the American Association for the Advancement of Science, AMA and Central Medical Society.

At the special June meeting the Board elected Dr. James O. Gilmore of Oxford, District 2, as secretary of the Board of Trustees. The chairman, the vice chairman, and the secretary make up the Executive Committee.

Occupational Health Congress Scheduled

The Council on Occupational Health of the American Medical Association will hold its 31st Congress on Occupational Health at Jackson Lake Lodge, Grand Teton National Park, Wyoming, Aug. 29-30, 1971.

The annual Physician's Award of the President's Committee on Employment of the Handicapped will be presented during the Congress program Aug. 30.

The program is acceptable for 12½ elective hours by the American Academy of General Practice.



Executive Committee of the Board of Trustees congratulates new District 5 member during recent Jackson meeting. From the left, Drs. Everett Crawford, vice chairman; Carl G. Evers of Jackson, new Trustee; J. T. Davis, chairman; and James O. Gilmore, secretary. Dr. Evers succeeded Dr. James L. Royals of Jackson who resigned because of professional commitments.

Dr. Ainsworth Is AUA President

Dr. Temple Ainsworth of Jackson was inaugurated 1971-72 president of the American Urological Association on May 20 during the annual convention at Chicago's Palmer House. The AUA is the largest professional association of urologists with 2,600 members.



Dr. Ainsworth

A native Mississippian, Dr. Ainsworth earned his B.S. degree from the University of Mississippi and his M.D. degree from the University of Virginia at Richmond. He completed internship and urology residency training at the University of Virginia hospital.

Upon completion of training, he began the private practice of urology in Jackson. He is on the attending staff of the Mississippi Baptist Hospital, St. Dominic-Jackson Memorial Hospital, University Hospital, Doctors' Hospital and Hinds General.

The AUA was founded in 1902 in New York City. It is devoted to scientific work in the specialty and publishes the world-renowned *Journal of Urology*.

The association's headquarters building is located in Baltimore. The AUA is divided geographically into eight sections and 11 branch societies, each of which has its own membership rules and procedures.

Long active in medical organization, Dr. Ainsworth served as president of the Mississippi State Medical Association 1967-68, chaired the association's Council on Medical Education for a number of years, and has been a member of the Council on Medical Service.

At the local level, the urologist was president of Central Medical Society in 1937. He was chairman and clinical professor of the division of urology, department of surgery, at the University of Mississippi School of Medicine 1954-68.

Dr. Ainsworth is a diplomate of the American Board of Urology and a Fellow of the American College of Surgeons. He has served as governor of the American College of Surgeons for six years and is a past president of the Mississippi chapter of ACS.

The new AUA president holds membership in the American Society for Pediatric Urology, American Association of Clinical Urologists, the Society of University Urologists, the American Medical Association and the Southern Medical Association.

SAMA Elects '71-72 Officers

W. James Alexander of Long Beach has been elected 1971-72 president of the Student American Medical Association chapter at UMC.

Other new officers are Edward R. Wilson, Jr., of Sardis, vice president; Robert B. Braham of Starkville, treasurer; and Walter R. Shelton, II, of Lambert, secretary.

The Mississippi chapter was named an outstanding chapter of the year at the national convention in St. Louis recently. One of five regional chapters selected, the UMC organization was reestablished last spring after 12 years of inactivity. Membership has grown from 75 to 135 students since last year.

Michael O'Neal of Hattiesburg has replaced Bill W. Long of Blue Springs as regional vice-president, selected from Region VII's nine medical schools.



New SAMA officers at UMC plan the chapter's programs for 1971-72. From left are Bob Braham, treasurer, Walter Shelton, secretary, Ed Wilson, vice president, and seated, Jim Alexander, president.

Mississippi's SAMA chapter has undertaken such projects as the MECO summer externship program, high school drug abuse education sessions; and a series of weekly talks at the Medical Center on Mississippi's changing health care system.


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Precautions: Should be used with caution in patients who have glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.
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Baptist Hospital Opens Cardiovascular Unit

Mississippi Baptist Hospital in Jackson has established the state's first cardiovascular laboratory to be located in a voluntary hospital. The new unit opened on July 1.

The announcement was made jointly by Zach T. Hederman, president of the hospital's Board of Governors, and by hospital administrator Paul J. Pryor.



Dr. Dear

Dr. H. Davis Dear of Jackson has been appointed director of the unit, according to Mr. Hederman. Dr. Dear will be full-time cardiologist on the staff and will be responsible for establishing and coordinat- the cardiovascular program.

Dr. Dear said the laboratory includes equipment for heart catheterization and facilities for exercise-testing of the heart.

In addition, there are facilities and a heart-lung machine in the hospital's operating areas for open-heart procedures. The first open-heart surgery has been scheduled for July 14. A special recovery room for open-heart patients staffed by specially-trained nurses is also being readied.

Dr. Dear is a native Jacksonian and a graduate of the University of Mississippi School of Medicine. He interned at Yale Medical School and did his residency at Yale-New Haven Hospital, then served a cardiology fellowship at the University of Alabama Medical Center in Birmingham.

He served on the staff of the University of Alabama Medical Center prior to becoming assistant professor of medicine and director of the cardiac catheterization laboratory at the University Medical Center in Jackson. He held this post until his appointment to the Baptist Hospital lab July 1, 1971.

MAGP Presents Check to SAMA



The Mississippi Academy of General Practice gave the University of Mississippi School of Medicine chapter of the Student American Medical Association a $200 check to help send Mississippi SAMA representatives to the national convention in St. Louis, Mo. Representing the Academy, Dr. Thomas Davis, left, presents the check to SAMA member Bill Long of Blue Springs, who is also president of a new student affiliate chapter of the Mississippi Academy of General Practice.

CHAMPUS Rules on Appliances Purchases

The CHAMPUS policy that allows the cost of durable equipment purchased under the Program for the Handicapped to be spread out over a period of months now covers prosthetic devices, hearing aids, orthopedic footwear and similar items required in the treatment of a handicapping condition.

In Mississippi, the CHAMPUS program is administered by the state medical association.

Officials of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) have explained that the original policy covered only oxygen tents, wheel chairs, hospital beds and other pieces of equipment but not the type of appliances authorized by this clarification of policy.

Under the Program for the Handicapped the sponsor is responsible for a cost-sharing portion each month based upon his grade, and CHAMPUS pays up to an additional $350 a month.

The clarification of policy allows the cost of durable equipment to be spread out over a period of months. For example, if a Sgt. (E-5) purchases a hospital bed for a total of $1200 over a period of four months, his share would total $100 while CHAMPUS would pay a total of $1100.

CHAMPUS officials state that persons who believe they may be entitled to payment of an additional amount on previously submitted claims as the result of the foregoing clarification of policy may submit a request for readjudication of their claims by writing to the Executive Director, OCHAMPUS, Denver, Colo. 80240.

UMC Ob-Gyn Seminar Is Conducted

The annual seminar of the University Medical Center Ob-Gyn Association was highlighted by the appearance of Dr. Charles E. Flowers of Birmingham, professor and chairman, department of obstetrics and gynecology, University of Alabama Medical Center, as special guest essayist.

Conducted on the Jackson medical center campus, the seminar was chaired by Dr. Lloyd Gary of Texarkana, Texas, president of the association made up predominantly of physicians who trained in the specialty at UMC.

Dr. Henry H. Webb of Jackson is vice president, and secretary-treasurer and program chairman of the association is Dr. Calvin Hull, assistant professor in the UMC department.

Dr. Flowers spoke on "The Management of Menstrual Dysfunction Through an Understanding of Normal Menstruation."

Other essayists were Dr. George R. Huggins whose paper was entitled "Family Planning in Mississippi" and Dr. Fred H. Ingram of Jackson who spoke on "Acardius Amorphus." Rowland B. Kennedy of Jackson, executive secretary of the state medical association, spoke on health and medical legislation and recent court decisions on abortion laws.

Dr. Huggins is assistant professor of the department, and Dr. Ingram is chief resident-designee for the 1971-72 training year.

The seminar was welcomed by UMC Dean and Director Robert E. Blount, and Dr. Henry A. Thiede, professor and chairman, presided over a portion of the meeting.

Officers were re-elected for 1972, and an evening social occasion closed the seminar. The 1970 William B. Gallagher Award went to Dr. Jerry C. Griffin, now in his medicine residency at UMC.

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IN CONCLUSION

Neurotoxicity of hexachlorophene is subject of warning by American Academy of Pediatrics. Report said that ingestion of a few ounces of 3 per cent solution has resulted in child death, also recorded after absorption through burns and eczema. AAP warning notes some products for oral use contain hexachlorophene and should not be used by children. Repeated washings or wet dressings for badly injured skin with hexachlorophene are also not recommended.

Social Security Administration has published white paper on determination of customary and reasonable fees for M.D.'s under Medicare, but winds up with 75th percentile of 1969 fees. Statement confirms that original concept of prevailing fees has been abandoned but says that program will move up to 75th percentile of 1970 fees on July 1, 1971. Principal complaint against Medicare is on disallowance of charges for services which Part B carriers have deemed "unnecessary."

South Dakota became seventh state to require fluoridation of public water supplies. Although nearly 100 million Americans drink fluoridated water in 7,400 towns and cities, most programs are local and not statewide. American Dental Association released data showing that annual average cost of dental care for child without fluoridated water is $117 against $29 for child drinking fluorides. AMA and most state medical associations endorse fluoridated water supplies.

Psychiatric patients are nearly 10 years younger than they were in 1958, but they can buy better voluntary, private insurance to pay for needed care. This is the finding of the Health Insurance Institute after survey of 800 member companies writing coverage. Psychiatric patients today average age 20 to 29 and receive nearly three times as much care as 30 to 39 age group of patients 12 years ago. Benefits reflect increases in allowances for in- and outpatient services.

New Health Manpower Act of 1971 is on House calendar with blessings of committee and administration. Measure will give most massive assistance yet to financially beleaguered medical schools, offering $2,500 each year per student for first three years and $4,000 for every senior graduated, a total of $11,500 for every M.D. trained. To qualify for increased assistance, schools would have to increase enrollment by 5 per cent or 10 students, whichever is greater.

Volume XII
Number 8
August 1971



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $7.50 per annum; $1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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Because bacterial proliferation in the urine is a function of time and retention,[1,2,3] *dawn can be…*

the darkest hour.



NEWSLETTER

August 1971

Dear Doctor:

The cost of professional liability insurance, anathema to half the nation's practicing profession, continues its upward spiral. New rates for 28,000 M.D.'s in New York show 45 per cent increase. Illinois has posted 25 per cent premium jump for 12,000 physicians. Worse yet, coverage is disappearing from insurance market in far west with only two carriers now doing business in California.

Dismal picture is shaping up in deep South as federated carriers are rumored to seek increase in Mississippi. Association's St. Paul program covers 700 members and remains fourth lowest cost protection in the nation, but increase here may be coming during this summer.

California Medical Association won lawsuit against state, forcing Medi-Cal (California Medicaid) to restore cuts in physicians' fees. Regan administration ordered slashes when billion dollar program overran budget last year, and state medical association sued to force program to stay at levels set by law. Trial court agreed with doctors and enjoined state against benefit reductions.

Another court decision on Medicaid fees, across the continent, was handed down in New York. An appellate ruling held that Commissioner of Health must fix reimbursement rates on reasonable relationship to costs. Suit was filed by nursing homes after cuts in payments had been ordered. Edict restored cost-related payments after state had cut ECF's to 50th percentile of per diem charges.

Quackery is alive and well and actively lobbying the Congress to put chiropractice into every government health care program. Recent survey shows 66 bills for chiropractic in House and Senate with 69 sponsors from 26 states, with one by Sen. Hubert H. Humphrey (D.F.L., Minn.). Gulf South is having nothing to do with move, and no sponsors are from Alabama, Arkansas, Louisiana, Mississippi, or Tennessee.

Moving quickly on President Nixon's policy of treating addicts in armed forces, CHAMPUS will now pay for treatment under private care. Policy not only includes treatment for drug addiction but also alcoholism and obesity. Regimen must be prescribed by a physician and will be paid as inpatient services, even in facilities not considered hospitals, such as rehab centers and half-way houses.

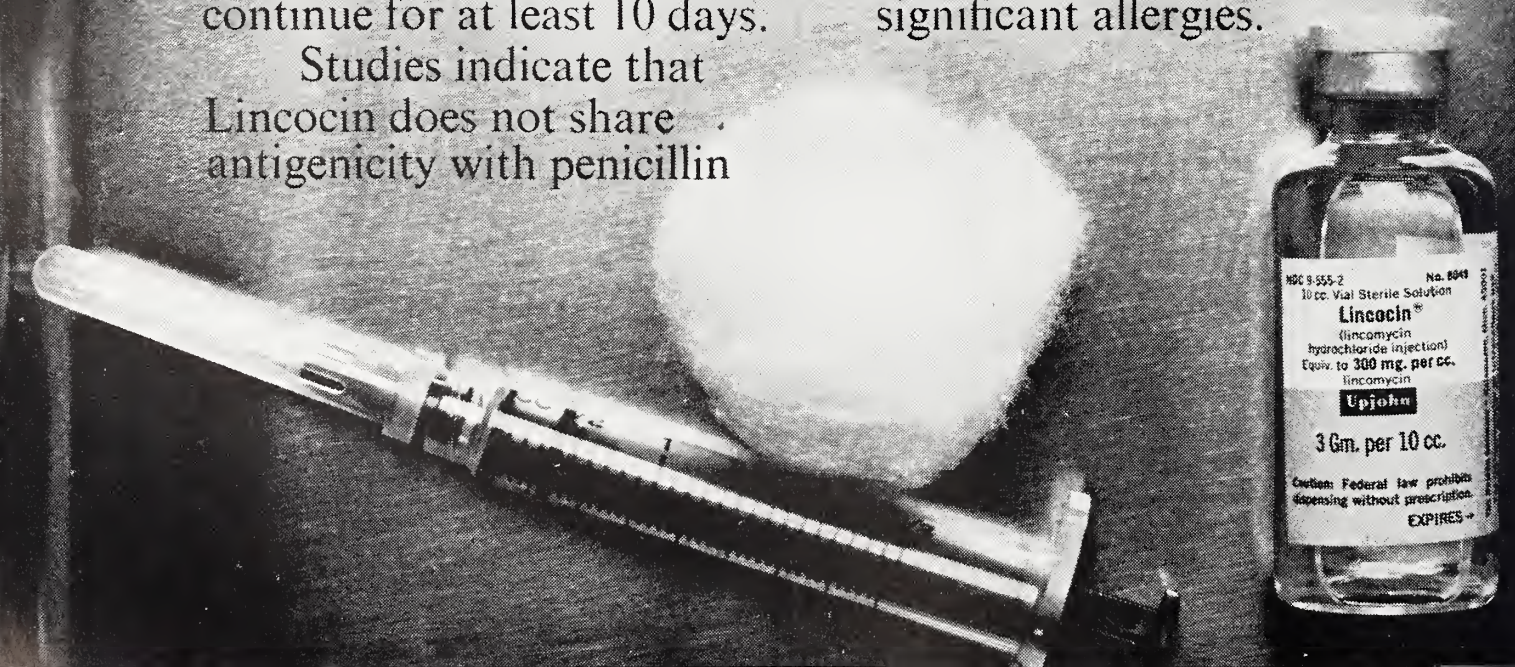
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DATELINE

Extendicare Buys Doctors Hospital

Louisville, Ky. - One of the nation's largest proprietary hospital and nursing home management organizations, Extendicare, Inc., has acquired the 120-bed Doctors Hospital at Jackson and the 85-bed hospital, Hickory Memorial, at Hickory, N.C. Latter purchase was for undisclosed amount of stock, cash, and notes, while Jackson buy was said to be stock swap. The Louisville-based corporation also will lease Lewis Hospital at Hohenwald, Tenn.

California Blue Shield Retrenches

San Francisco - Squeezed financially after two years of posting losses, California Blue Shield has instituted tough measures to rebuild reserves and reduce outflow of money. Plan is withholding 5 per cent of usual and customary fee payments to physicians, stopped paying for inpatient diagnostic tests without treatment, and put nonmember M.D.'s on fee schedules. Salaries of plan employees are frozen, and rates to subscribers have been increased.

MHA Scores With Uniform Claim Form

Jackson - The Mississippi Hospital Association won fight for a standard uniform claim form for use by hospitals in filing third party claims. New form is protected by state law which makes use mandatory. Only exceptions are Medicare and Medicaid which state cannot force to use because of federal funding. The single-page standard claim form was carefully developed by hospital association in consultation with the insurance industry and will improve claims processing efficiency.

Mississippi Tops Part B Assignments

Atlanta - Mississippi M.D.'s accept more assignments under Medicare's Part B than physicians in any of the nine southeastern states. Most recent figures show Mississippi doctors are accepting 84.6 per cent assignments for regional high against 39.2 per cent assignments in Florida, low rate in area. Average acceptance rate is over 75 per cent. The studies also show that assignment rate mounts after June when beneficiaries have met the deductible of $50.

Manpower Bill Helps All Disciplines

Washington - The House-passed H.R. 8629, the Comprehensive Health Manpower Training Act of 1971, has fine print helping nearly all health-related disciplines. Biggest news was subsidy of $2,500 per medical student per year and bonus of $4,000 for each M.D. graduate. Bill would also subsidize pharmacy, optometry, and podiatry students to tune of $800 per year, while veterinary medical students rate $1,500 each annually. Schools of dentistry would receive same benefits as medical schools.

Students Learn While Sleeping

Scientists at the University of Florida have reported studies that they say represent the first clear-cut evidence of some possibility of learning while asleep. The studies were supported by HEW's National Institute of Mental Health, Health Services and Mental Health Administration.

Drs. C. Michael Levy and Wilse B. Webb have demonstrated that sleep learning can occur during the deepest stages of slumber as well as during the lighter stages. Furthermore, the ability to learn while sleeping appears to improve with training.

Participating in the studies were high school and college students who attempted to learn 12 pairs of Russian/English nouns while asleep. None of the subjects had any prior knowledge of Russian, and the noun pairs used had been shown to have a zero chance of being guessed correctly. In one part of the study, the level of learning approached 30 per cent.

The sleep learning studies followed this format. Before the subjects fell asleep on each of two adaptation nights, a "conditioning" tape was played. The tape began: "You know that your ability to learn while you are asleep depends entirely on your willingness to cooperate . . . it will be very easy for you to learn to fall into a very deep sleep and you will learn. . . ."

Following this, five nights were devoted to actual sleep learning. Before the recording of noun pairs was played, the sleeping subjects heard the words: "This is your Russian teacher. . . . You are asleep and relaxed and you can hear my voice, and you will not wake up. . . . You will remember these words and their meanings forever. . . ."

The subjects heard the same "training" tape the first two nights of the study and one of the remaining three tapes each of the next three nights.

In one part of the study, the average recall over all nights for deep sleep learning was approximately 13 per cent. In another part of the study, in which the training tapes were played while the students were in a light sleep stage early in the night, average retention scores ranged from 10 per cent for the first three nights to 17 per cent for the last two nights. When the subjects heard the training tapes during light sleep late in the night, their scores ranged from 12 to 30 per cent retention.

The pattern of scores over the five nights indicated that the ability to learn while asleep improves with training and practice.

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DOW THE DOW CHEMICAL COMPANY, Rx Pharmaceuticals, Indianapolis

AHA Convention To Feature Sec. Richardson

Elliot L. Richardson, Secretary of Health, Education and Welfare, will be a featured General Assembly speaker during the American Hospital Association's 73rd annual convention August 23-26 at Chicago.

Mr. Richardson will address the General Assembly session on Tuesday afternoon (Aug. 24) and speak on "Restructuring the Health Delivery System." All General Assembly sessions will held in the Arie Crown Theater of McCormick Place.

Earl Perloff, chairman of the AHA's Special Committee on the Provision of Health Services and chairman of the Board of Trustees of Albert Einstein Medical Center and Philadelphia General Hospital, will be the General Assembly speaker on Monday afternoon (Aug. 23). Perloff will discuss "Ameriplan," the AHA's proposal for restructuring the health care delivery system.

Other General Assembly speakers include Rep. Paul G. Rogers (D. Fla.), chairman, Public Health and Welfare Subcommittee, House Interstate and Foreign Commerce Committee, and Donald E. Johnson, Administrator of the Veterans Administration.

On Thursday afternoon (Aug. 26), Dr. Edwin L. Crosby, executive president of the American Hospital Association, and Walter J. McNerney, president of Blue Cross Association, will discuss "Hospital-Blue Cross Relationships: National and Local."

AHA's annual convention is the largest health meeting in the nation and will bring together nearly 20,000 professionals to discuss current trends in health care.

More than 85 instructional sessions and subassemblies and specific educational programs, ranging from Ameriplan (AHA's blueprint for reorganizing the health care system), hospital costs, treating drug addiction and alcoholism in hospitals, legislation affecting the health care field, to the new hospital accreditation standards will be conducted during the four days in specially constructed theaters.

Some 500 exhibits from health care and related industries will be organized around the five areas of interest which are maintenance and engineering, medical equipment, management and systems, food service, and architecture.

Brief Summary of Prescribing Information— 9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet b.i.d.
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
August 1971, Vol. XII, No. 8

ORIGINAL PAPERS

New Anesthetic Agents and Old Complications

JAMES H. SAMS, M.D., and
JESSE G. MULLEN, M.D.
Jackson, Mississippi

KETAMINE AND INNOVAR are two newly marketed anesthetic agents reported to be extremely safe which have gained rapid and widespread popularity. Although they are useful additions to the armamentarium of the anesthesiologist, some, believing these agents to be completely safe, may be tempted to use them without observing the necessary precautions attending any general anesthetic procedure. Ketamine in particular has been said to be "so safe that it is dangerous."[1]

The object of this paper is to present some of the important problems that may occur with the administration of these agents which should serve as a warning against their use by the inexpert and in areas where facilities are not available for tracheal intubation, controlled ventilation and other resuscitative measures. Many excellent papers have been published to which the reader is referred for a more complete discussion concerning the pharmacology, indications and precautions as to use.[2-7]

Ketamine is a non-narcotic and non-barbiturate agent. It is a rapid acting, non-volatile anesthetic which usually produces profound analgesia while maintaining active pharyngeal-laryngeal reflexes and normal or slighly enhanced skeletal muscle tone. It stimulates the cardiovascular and respiratory systems, and some antiarrhythmic cardiac action is thought to occur.

Ketamine and Innovar are two newly marketed anesthetic agents which have gained widespread popularity. Both are valuable drugs when used with the usual precautions required for any general anesthetic, say the authors. They point out complications that can occur and with each drug the absolute necessity of having available proper resuscitative equipment and trained personnel.

Two well-known disadvantages of the drug are occasional episodes of severe hypertension and vivid dreaming.

The blood pressure of a typical normotensive patient can be expected to increase approximately 15 to 25 per cent after Ketamine injection. In patients with a previous history of hypertension this increase may greatly exceed predicted levels, and frequently fails to occur in the hypovolemic patient. Associated with this hypertensive response may be an elevation of the cerebral spinal fluid pressure to unpredictable

From the Department of Anesthesiology, University of Mississippi School of Medicine, Jackson, Miss.

levels. This increase in cerebral spinal fluid pressure would invalidate any baseline study of cerebral spinal fluid pressure taken prior to certain diagnostic neurosurgical procedures, such as a pneumoencephalogram for which Ketamine is used.

The vivid dreaming and occasional hallucination produced by Ketamine appear to be related to patient age, dosage, route of administration, and amount of postoperative stimulation. When used in pediatric patients employing minimum dosage administered by the intramuscular route with care being taken to avoid postoperative stimulation, the incidence of this complication is greatly reduced.[2] Some investigators have suggested that Ketamine should be used almost exclusively in pediatrics and its use should be limited in adults to special selected cases. A common request from adult patients who have experienced disturbing dreams is that Ketamine not be given them again.

RESPIRATORY DEPRESSION

Induction with Ketamine may produce a transient, mild respiratory depression which is usually followed immediately by an increase in respiration. However, prolonged respiratory depression or even apnea may result from a relative or absolute overdose. Ketamine administered in the presence of an upper respiratory infection, even in unsuspected cases, may produce severe coughing and breath holding to the point of cyanosis and bradycardia.[4] The reflexes of the respiratory tract appear to remain intact or become accentuated with Ketamine. Under these circumstances the presence of secretions in the vicinity of the larynx can cause laryngo-bronchospasm and in the pharynx reflex breath holding.

Ketamine produces profuse salivation. Respiratory insufficiency may therefore be due to mechanical airway obstruction resulting from retained secretions. In some patients the tongue falls back into the pharynx obstructing the airway. Thus, even though the airway usually remains patent, an occasional patient will need airway support or even tracheal intubation.

The literature states that should vomiting occur the patient is safe from aspiration due to these intact reflexes. However, should vomiting occur and the patient fail to turn his head to the side to allow for drainage, the vomitus can produce breath holding, laryngospasm or even aspiration. (Cases of aspiration have occurred under local anesthesia due to the supine position of the patient.) It is therefore mandatory that these patients have constant attention during anesthesia and an effective antisialagogue such as Scopolamine or Atropine prior to induction.

A case history in which a respiratory problem was encountered is presented as an illustration. In addition, we have had other patients develop respiratory difficulties ranging from mere breath holding and mechanical obstruction to frank laryngospasm.

UMC CASE STUDY

This was the first University Medical Center admission for this two-year-old male who sustained lacerations about the face and mouth resulting from a fall. On admission the only abnormal physical finding was a short systolic ejection murmur, grade I/VI. Rectal temperature was 100.6°F. Lab Data: Hgb. 11.2 gms. per cent; Hct. 34 per cent, Urinalysis—negative, WBC 16,500—no differential. A chest x-ray was not taken. The child weighed 30 pounds.

Preoperative medication of Demerol 30 mgms., Nembutal 30 mgs. and Atropine 0.2 mgm. was administered at 2:05 p.m. Vital signs were: pulse rate 160/min.; blood pressure 90/60 mm. Hg, respiratory rate 28/min. Induction of anesthesia was started at 3:25 p.m. with the intramuscular injection of 150 mgms. of Ketamine (five mgms./lb.).

Shortly after induction the patient produced excessive amounts of secretions that required suctioning. Immediately following one episode of oropharyngeal suctioning, the patient suddenly developed what appeared to be laryngospasm, the sequel to which was a cardiac arrest. Subsequent to positive pressure oxygen, tracheal intubation and external cardiac massage, the heart sounds, pulse rate and blood pressure quickly returned to normal and the procedure was completed without any further difficulty. Diagnosis of a mild bilateral apical pneumonia was made from findings on the chest x-ray taken postoperatively in the recovery room. (See Figure 1.)

DIAGNOSIS

The most likely diagnosis considering the leukocytosis and fever would be a preexisting upper respiratory infection which predisposed to the increase in secretions and eventual outcome of the case. The possibility of an aspiration pneumonitis must also be considered. Regardless, the presence of secretions probably produced a borderline hypoxia in addition to necessitating suctioning which touched off the laryngospasm leading to the cardiac arrest.

Innovar is a non-volatile anesthetic mixture consisting of Fentanyl, a potent synthetic narcotic, and Droperidol, a neuroleptic agent in a 50 to 1 weight to weight ratio. Neuroleptic agents

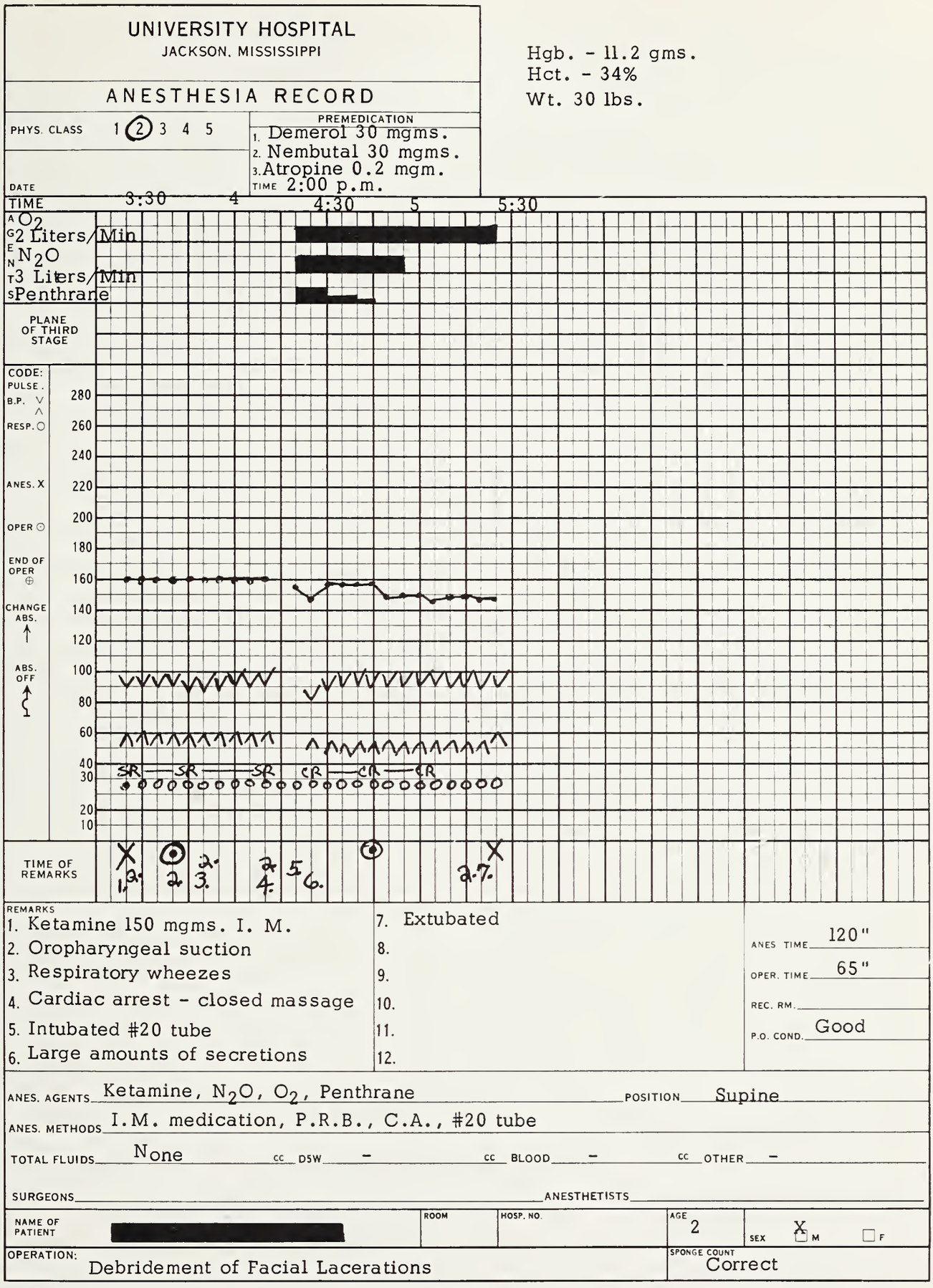

UNIVERSITY HOSPITAL
JACKSON, MISSISSIPPI
ANESTHESIA RECORD
PHYS. CLASS 1 2 3 4 5
PREMEDICATION
1. Demerol 30 mgms.
2. Nembutal 30 mgms.
3. Atropine 0.2 mgm.
TIME 2:00 p.m.
DATE
Hgb. - 11.2 gms.
Hct. - 34%
Wt. 30 lbs.
TIME 3:30 4 4:30 5 5:30
AIR
GAS 2 Liters/Min
ETHER N_2O
TRIL 3 Liters/Min
SPEC Penthrane
PLANE OF THIRD STAGE
CODE:
PULSE.
B.P. V ^
RESP. O
ANES. X
OPER ⊙
END OF OPER ⊕
CHANGE ABS. ↑
ABS. OFF ↑
280
260
240
220
200
180
160
140
120
100
80
60
40
30
20
10
SR SR SR CR CR CR
TIME OF REMARKS
1. 2. 2 3. 4. 5 6. 7.
REMARKS
1. Ketamine 150 mgms. I. M.
2. Oropharyngeal suction
3. Respiratory wheezes
4. Cardiac arrest - closed massage
5. Intubated #20 tube
6. Large amounts of secretions
7. Extubated
8.
9.
10.
11.
12.
ANES TIME 120"
OPER. TIME 65"
REC. RM.
P.O. COND. Good
ANES. AGENTS Ketamine, N_2O, O_2, Penthrane
POSITION Supine
ANES. METHODS I.M. medication, P.R.B., C.A., #20 tube
TOTAL FLUIDS None cc D5W - cc BLOOD - cc OTHER -
SURGEONS
ANESTHETISTS
NAME OF PATIENT [redacted]
ROOM
HOSP. NO.
AGE 2
SEX X M F
OPERATION: Debridement of Facial Lacerations
SPONGE COUNT Correct

Figure 1

are a group of drugs whose site of central nervous system action is the subcortical areas of the brain stem, clinically characterized by antiemesis, disconnection (mental withdrawal), hypomotility, homeostatic stabilization by blockade of alpha-adrenergic receptors, temperature lowering and barbiturate and opiate potentiation. Fentanyl is clinically characterized by potent analgesia, respiratory depression, and skeletal muscle rigidity.

One of the most impressive features concerning Innovar is the variability in patients' response to dosage. The recommended dose is 1 cc per 20-25 pounds of body weight, however, some adults may only require a total dose of 1 or 2 cc for major surgery, whereas others may obviously still be aware of a surgical stimulus after receiving twice the recommended dose. Therefore, dosage calculated on a weight basis is unreliable and will eventually result in overshooting or else falling short of the ideal anesthetic requirement. Dosage must be titrated according to each patient's response. The following case history illustrates one example of extreme tolerance.

INNOVAR CASE STUDY

This was the first University Medical Center admission for this 60-year-old male. Except for progressive ischemic changes in his lower extremities, he was in apparent good general health. Past history was unremarkable except for a right lumbar sympathectomy performed 13 years prior to admission. A history of heavy alcohol intake was elicited; however, almost no alcohol intake occurred during the past two years. Drug abuse was denied. Liver, kidney and hematological tests were within normal limits except for a serum potassium of 2.8 mEq./L. Positive physical findings included moderate gynecomastia with several small spider angiomata scattered over the chest area. The liver was palpable five centimeters below the right costal margin. Pulses were decreased in the right leg with associated ischemic skin changes being present. Blood pressure was 110/60 mm. Hg, pulse rate, 80/minute, respiratory rate, 22/minute, temperature, 99°F, and weight, 170 pounds.

The patient was brought to the operating room following a preoperative medication consisting of Demerol 75 mgms., Nembutal 100 mgms., and Atropine 0.5 mgm. He was not well sedated. Induction was accomplished with the intravenous injection of Innovar 12 cc and Surital 200 mgms. plus the inhalation of a nitrous oxide-oxygen mixture in a four liter to two liter flow ratio via a face mask. The patient was still very light and an additional dose of Surital 200 mgms. was injected intravenously followed by Anectine 60 mgms. to accomplish intubation.

Following this and prior to the start of surgery an additional 12 cc of Innovar was required. When the incision was made the patient moved and an additional 18 cc of Innovar was given during the following 30 minutes interspersed with occasional increments of Anectine 40 mgms. to prevent purposeful movements of the extremities. During the next hour the patient received Innovar 10 cc and Sublimaze 4 cc and continued to require intermittent Anectine injections of 40 mgms.

PATIENT RESPONSE

When the nitrous oxide was discontinued the patient opened his eyes and pulled his endotracheal tube out. He complained of pain and seemed mentally alert. Blood pressure and pulse rate were stable throughout the procedure and urine output was adequate. Anesthesia time was 150 minutes during which the patient received a total dose intravenously of Innovar 52 cc, Surital 400 mgms., Sublimaze 4 cc, and Anectine 240 mgms. (See Figure 2.)

As with other depressants, rapid intravenous injection or overdosage of Innovar invariably results in a fall in blood pressure. Fentanyl routinely produces hypotension and bradycardia due to central vagal stimulation unless prevented by pretreatment with Atropine. Droperidol administration leads to an immediate sharp drop in blood pressure with recovery time being approximately one minute.

DROPERIDOL

Droperidol also inhibits the pressor effects of epinephrine by alpha receptor blockade, the action of a single dose lasting six to 12 hours. Such inhibition may measurably forestall the irreversible aspects of shock; however, should this result in hypotension which is unwanted in a particular patient, the use of vasopressors with predominant peripheral action should be used to restore vascular tone. Therefore, even though Innovar has been advocated as a safe anesthetic for the poor risk patient since it affords a fairly stable cardiovascular system and protects against shock,[6] associated hypotensive aspects may be undesirable for the patient whose cardiovascular status is compromised or unstable.

The respiratory system is probably subjected to the most untoward responses. Since Innovar induction requires at least three to five minutes, any attempt at positive pressure respiration prior to this time may produce laryngospasm which can occur in any lightly anesthetized patient. As

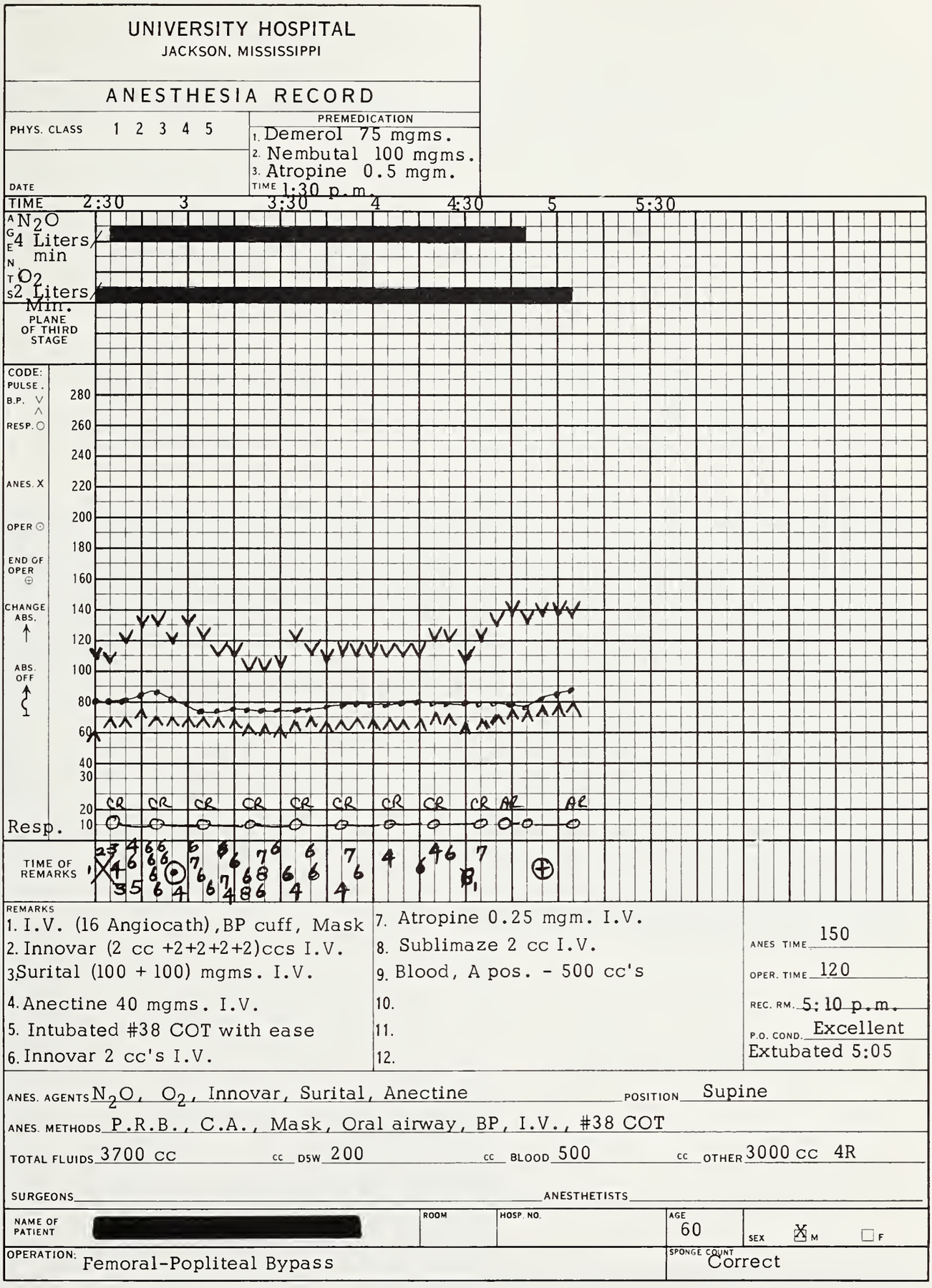

UNIVERSITY HOSPITAL
JACKSON, MISSISSIPPI
ANESTHESIA RECORD
PHYS. CLASS 1 2 3 4 5
DATE
PREMEDICATION
1. Demerol 75 mgms.
2. Nembutal 100 mgms.
3. Atropine 0.5 mgm.
TIME 1:30 p.m.
TIME 2:30 3 3:30 4 4:30 5 5:30
ANES. AGENTS N_2O 4 Liters/min O_2 2 Liters/Min.
PLANE OF THIRD STAGE
CODE:
PULSE .
B.P. V ^
RESP. O
ANES. X
OPER ⊙
END OF OPER ⊕
CHANGE ABS. ↑
ABS. OFF
280 260 240 220 200 180 160 140 120 100 80 60 40 30 20 10
Resp.
TIME OF REMARKS
REMARKS
1. I.V. (16 Angiocath), BP cuff, Mask
2. Innovar (2 cc +2+2+2+2)ccs I.V.
3. Surital (100 + 100) mgms. I.V.
4. Anectine 40 mgms. I.V.
5. Intubated #38 COT with ease
6. Innovar 2 cc's I.V.
7. Atropine 0.25 mgm. I.V.
8. Sublimaze 2 cc I.V.
9. Blood, A pos. - 500 cc's
10.
11.
12.
ANES TIME 150
OPER. TIME 120
REC. RM. 5:10 p.m.
P.O. COND. Excellent
Extubated 5:05
ANES. AGENTS N_2O, O_2, Innovar, Surital, Anectine
POSITION Supine
ANES. METHODS P.R.B., C.A., Mask, Oral airway, BP, I.V., #38 COT
TOTAL FLUIDS 3700 cc cc D5W 200 cc BLOOD 500 cc OTHER 3000 cc 4R
SURGEONS
ANESTHETISTS
NAME OF PATIENT
ROOM
HOSP. NO.
AGE 60
SEX ☒ M ☐ F
OPERATION: Femoral-Popliteal Bypass
SPONGE COUNT Correct

Figure 2

documented in the literature, rapid intravenous injections of Fentanyl may produce bronchial constriction, diaphragmatic and intercostal muscle rigidity resulting in increased resistance to ventilation. (Histamine is not thought to be released.) Respiratory depression can also occur.

The combined use of Innovar with several other commonly used agents can be hazardous in asthmatics or patients with obstructive pulmonary disease such as emphysema, where a degree of bronchospasm and increased tracheo-bronchial reflex irritability exist. As previously mentioned, Innovar may cause bronchial constriction even in normal patients; coupled with agents which have a potential for histamine release, an episode of severe bronchospasm may be precipitated transforming an otherwise simple procedure into a harrowing experience. Common agents associated with histamine release are morphine, codeine, tubocurarine, gallamine, thiopentones, and dextran.

Agents or conditions which lead to accentuation of parasympathetic activity should also be regarded as capable of producing bronchospasm when used in conjunction with Innovar. Hexafluorenium, for example, inhibits the activity of plasma cholinesterase thus retarding acetylcholine hydrolysis leading to parasympathomimetic activity which includes bronchial constriction. Moderate patient cooling, seen occasionally in children, increases the activity of acetylcholine, leading to increased tone of bronchial musculature.

Postoperatively, patients may be in the recovery phase for long periods of time due to the prolonged action of Droperidol which lasts six to 12 hours. Droperidol potentiates narcotics of all types; therefore, for at least 12 hours after surgery all dosages of narcotics should be reduced one half to one fourth the usual amount prescribed. If by accident a standard dose of narcotic is administered, the patient may be rendered unresponsive for several hours.

Psychic symptoms which may be produced by Droperidol in the postoperative period range from restlessness to hallucinations. These patients may also have suicidal tendencies. Extrapyramidal signs such as twitching, tremors, and oculogyric crisis may occur and last for as long as 12 hours. These extrapyramidal manifestations are usually more common in younger patients. Thus, facilities for postoperative surveillance and care must be available.

SUMMARY

Both Ketamine and Innovar are valuable drugs when used with the usual precautions that are required for any general anesthetic. They are not a panacea and definitely should not be used as casual agents for outpatient anesthesia when the proper resuscitative equipment and trained personnel with a working knowledge of the agents are not available. To quote an old adage, "There are no safe anesthetic agents or techniques—only safe anesthesiologists." ★★★

2500 North State Street (39216)

Generic and Trade Names of Drugs

Ketamine—Ketaject, Ketalog
Halothane—Fluothane
Atropine
Scopolamine
Succinylcholine—Anectine
Thiamylal—Surital
Fentanyl—Sublimaze
Fentanyl and Droperidol—Innovar
Gallamine—Flaxedil
Meperidine—Demerol
Pentobarbital—Nembutal
Morphine
Codeine
Hexafluorenium—Mylaxen
d-tubocurarine—Curare

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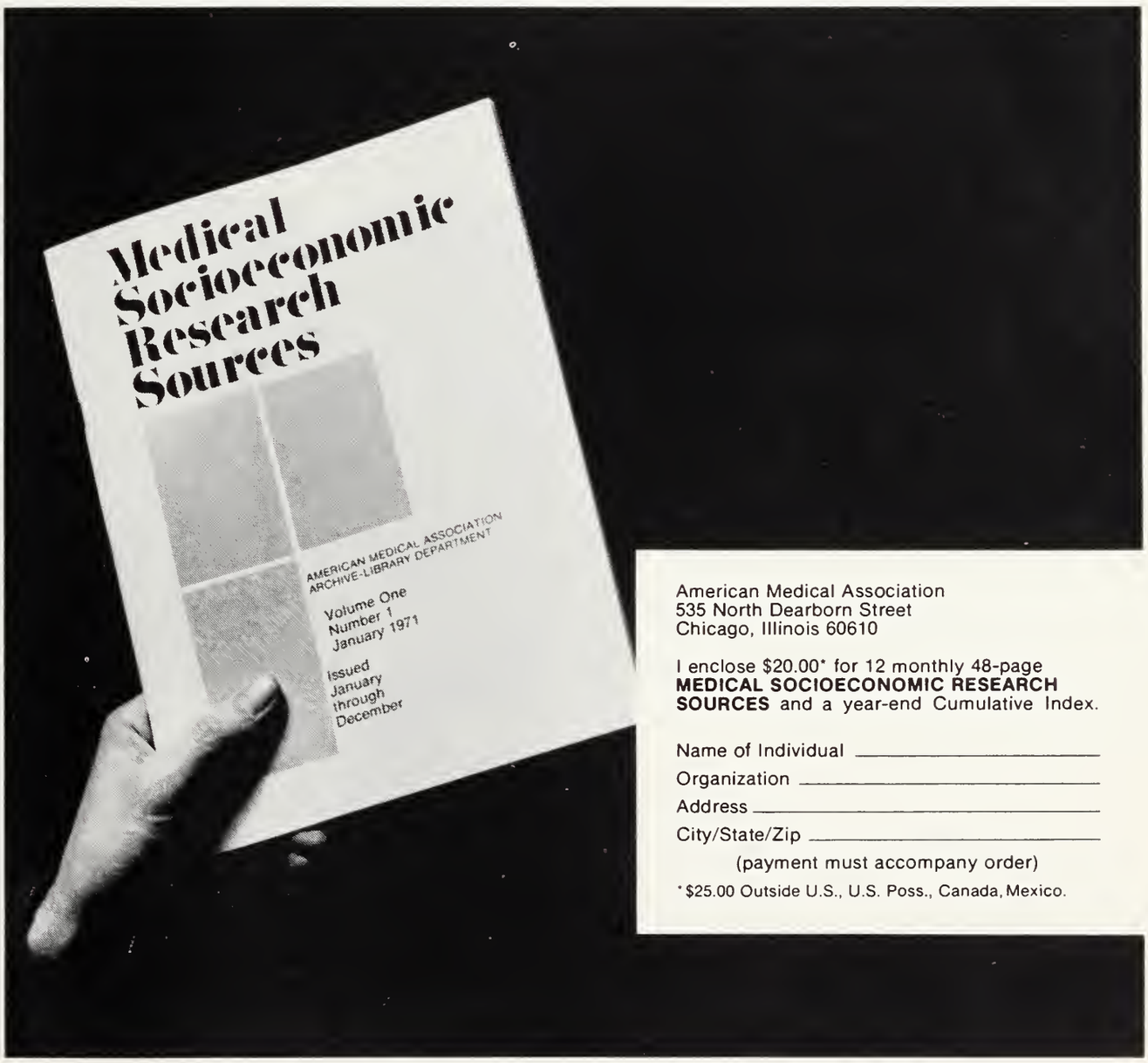
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ELMER J. HARRIS, M.D.
Jackson, Mississippi

LIPOMAS ARE BENIGN tumors composed of fatty tissue which are likely to arise in regions where fat cells are normally present. Lipomas of the stomach are somewhat rare, constituting approximately two per cent of benign tumors with benign tumors representing less than five per cent of all roentgenographically diagnosed gastric tumors.[1]

CASE REPORT

The patient, a 67-year-old white female, was admitted to Mississippi Baptist Hospital with a chief complaint of abdominal tenderness. A gall stone was demonstrated upon cholecystographic study. A gastrointestinal series showed a mass in the antrum of the stomach measuring 5.5 cm. in diameter (see Figure 1) and appearing to be less dense than surrounding tissue. The mass changed shape upon pressure and with peristalsis (see Figure 2). The mucosa over the mass appeared intact without ulceration. It was the impression that this mass most likely represented a lipoma. At laparotomy, a cholecystectomy was performed and the lipoma was removed from the stomach, this being in a subserosal location.

DISCUSSION

Less than one-third of gastric lipomas are felt to produce symptoms.[2] When the lipoma is in a subserous layer, it projects outward while if it has a submucosal location, it protrudes into the stomach lumen and may cause erosions and ulceration with bleeding.

It has been stated that approximately one-third of the lipomas of the stomach have overlying



Figure 1. Note the large radiolucent mass within the antrum of the stomach, this being more radiolucent than surrounding tissues.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Hospital, Jackson, Miss.

ulcerations.[3] The antrum of the stomach is the usual site of involvement and the lipoma may be sessile or pedunculated. If pedunculated, it may initiate intussusception or intermittent pyloric obstruction by a ball-valve mechanism.

Typical radiographic changes by which lipomas can be recognized are: a) relative radiolucency; b) compressibility with change in shape depending upon pressure and peristaltic activity,[4] this being attributed to fluid-like nature of fatty tissue; and c) smooth well-defined margins. ★★★

1190 North State Street (39201)

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1. Culver, G. J., and Dobrak, A.: *Submucosal Gastric Lipoma. Report of a Case Presenting an Interesting Roentgen Sign.* American Journal of Roentgenology 64:938-939, December 1950.
2. Badner, D. H., and Carlan, M.: *Gastric Lipoma.* Surgery 31:909-914, June 1952.
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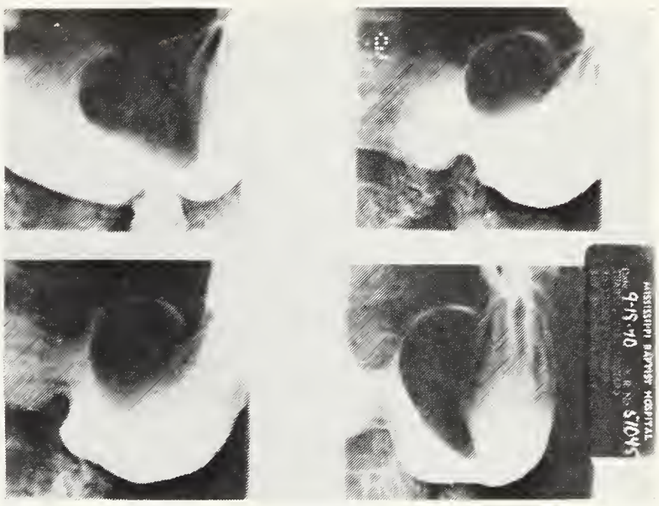


Figure 2. On spot films, notice change in size and shape of this mass with change in peristalsis and compression by spot cone.

4. Culver, G. J., and Toffolo, R. R.: *Criteria for Roentgen Diagnosis of Submucosal Gastric Lipoma.* Radiology 82:254-257, February 1964.

IT DOES MACH A DIFFERENCE

Sen. Proxmire and other critics of the supersonic transport were correct: The aircraft is dangerous. For example, look what it has done to Seattle.

But by way of consolation, the Congress will soon consider legislation for subsidizing design and construction of a subsonic transport. It will fly 42 miles per hour and stop for school busses.

Counsel to Authors

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10, but when justified to the Editors, additional references will be considered for publication. Each will be critically examined, and only valid, primary references will be published. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

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A thesis summary of 75 to 100 words must accompany each manuscript separately from the text.

Reprints may be obtained at cost plus shipping charges from the association and should be ordered prior to publication. The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*

Proceeding of the House of Delegates

103rd Annual Session
May 3-6, 1971
Biloxi, Mississippi

THE 68TH ANNUAL SESSION of the House of Delegates was convened during the 103rd Annual Session of the Mississippi State Medical Association, in pursuance to lawful notice given, on May 3, 1971, in the Top of the Sheraton, the Sheraton-Biloxi, Biloxi, Mississippi at 9:05 o'clock in the morning by Dr. Paul B. Brumby, President. The invocation was spoken by the Rev. W. S. Cameron, pastor of the First Methodist Church of Biloxi.

After extending greetings, Dr. Brumby announced that the Speaker of the House of Delegates, Dr. William E. Lotterhos of Jackson, was absent recovering from recent surgery. He presented the Vice Speaker, Dr. John B. Howell, Jr., of Canton, and announced appointment of Dr. Stanley A. Hill of Corinth as Speaker *Pro Tempore,* also presenting him. The Reference Committee on Credentials reports a quorum of 108 members of the House of Delegates present and seated.

ACTION OF HOUSE

On motion by Dr. Frank W. Bowen of Carthage, second by Dr. Mal S. Riddell, Jr., of Winona, the House of Delegates voted unanimously to send an expression of good wishes and fraternal greetings to Dr. William E. Lotterhos of Jackson.

ANNOUNCEMENT OF REFERENCE COMMITTEES

Reports of Officers and Board of Trustees
Charles R. Jenkins, Laurel, Chairman
Charles N. Floyd, Gulfport
S. Jay McDuffie, Nettleton
Walter H. Rose, Indianola
Victor E. Landry, Lucedale

Medical Practices
James M. Dabbs, Waynesboro, Chairman
Joe S. Covington, Meridian
J. Dan Mitchell, Jackson
Omar Simmons, Newton
James L. Thornton, New Albany

Miscellaneous Business
William H. Preston, Jr., Booneville, Chairman
Wendall B. Holmes, McComb
John R. Lovelace, Batesville
James M. Packard, Jackson
Edward Pennington, Ackerman

Credentials
Raymond S. Martin, Jr., Jackson, Chairman
Samuel B. Caruthers, Grenada
D. L. Bolton, Picayune

Rules and Order of Business
E. L. Whitfield, Florence, Chairman
Frank M. Acree, Greenville
J. Kinabrew Williams, Jr., Pascagoula

APPOINTMENT OF TELLERS AND SERGEANTS-AT-ARMS

C. D. Taylor, Jr., Pass Christian, Chairman
William M. Gillespie, Jr., Meridian
Jack A. Stokes, Pontotoc

REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

To assist the Speaker and Vice Speaker in the orderly conduct of the proceedings of this House of Delegates, your Reference Committee on Rules and Order of Business makes the following recommendations:

Conduct of Business. Under the By-Laws, the business of the House must be conducted according to *Robert's Rules of Order, Newly Revised,* and the Speaker and Vice Speaker should prescribe the order of business as set out in the By-Laws. To insure proper recording of the transactions, all delegates recognized should identify themselves. Except for distinguished visitors and those having official capacity in the association, unanimous consent should be obtained for

extending the privilege of the floor to nonmembers of the House of Delegates. The report of the Reference Committee on Credentials should constitute the formal and official roll call of the House.

Reference Committees. The purpose of reference committees is for affording all members of the association an opportunity to discuss their views on matters under consideration by the House of Delegates.

Reports. All reports and resolutions presented should be referred to the appropriate reference committee by the chair immediately after their presentation, the only exception being those which are of such a nature as to require no further consideration and are, therefore, ready for decision by vote of this House. Reports published in the *Handbook of the House of Delegates* are considered to have been formally presented and should be referred to appropriate reference committees by the chair. Debate should be reserved on all such presentations until such time as the reference committees conduct formal hearings and when they report to the House.

Resolutions. To avoid burdensome tasks upon the reference committees and to insure that all members have adequate opportunity to discuss their views, the House should permit no introduction of resolutions after the present meeting except for (1) matters of an emergency nature, the validity of such emergency to be determined by majority vote, (2) matters relating to a scientific section of scientific work, and (3) proposed amendments to the Constitution and/or By-Laws which would then lie on the table for one year.

The report of the reference committee was adopted.

ADOPTION OF TRANSACTIONS

On motion by Dr. Lawrence W. Long of Jackson, second by Dr. H. C. Ricks, Sr., of Jackson, the Transactions of the 67th Annual Session of the House of Delegates, 102nd Annual Session of the Association, May 11-14, 1970, published in Volume XI, Number 8, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, August 1970, were adopted.

REMARKS OF THE SPEAKER

The Remarks of the Speaker were prepared by Dr. William E. Lotterhos and presented in his behalf by the Vice Speaker, Dr. Howell:

Dr. John B. Howell, Jr.: Your Speaker and Vice Speaker extend a warm and fraternal welcome to each member of the House of Delegates. We hope and believe that good preparations have been made for you at your 103rd Annual Session of our association. We have endeavored to continue to make refinements in the mechanics and staffing of the House to assist your making wise and worthy decisions.

To wear a blue badge signifies something special: At some point in time past, your peers voted an expression of confidence in your capacity to represent them. This has given you the responsibility of working diligently at the four-day task of being a good delegate. And there is more to the job than listening to addresses and reports, presenting resolutions, and voting for next year's officers.

Each of us must make a conscientious effort to contribute constructively to the deliberations and work of the House. This is neither the time nor the place for personal pique but rather a time for the better idea. It is the time to give careful and serious consideration to the work of those which lies before you, and in no few instances, a single printed page may well represent six trips to Jackson for meetings, hours of study and discussion, and not a little burning of the midnight oil back at home.

So it follows that these labors merit and, indeed, demand our respectful appraisal, our most constructive thought, and our informed decisions. Nothing less will do, and your Speakers have confidence that you will do nothing less.

Our representative processes require full discussion on every matter before us, and our system of reference committees assures that any member of the association shall have his day to make heard his say. Unlike committees of governmental legislative bodies, our reference committees cannot kill an issue nor can they prevent its coming to you for decision by the majority.

But these reference committees cannot do their best work unless you are there to help. Your Speaker feels that it is an affront to the committee and the members of the House when a delegate stays away from the hearing and debate only to get up on the floor the last day to make known his views. To be sure, discussion is invited when these committees present reports, but there should be discussion by those who have already participated in the formulation of the committee's recommendations.

Your Speakers encourage you to keep it simple as you make your decisions. Parliamentary procedure can be as simple or as complicated as the deliberative body wishes, but the quality of its decisions is more likely than not to bear a direct relationship to the uncomplicated, orderly, and courteous manner in which the decisions are reached.

If you disagree with a recommendation of a

reference committee or with a motion properly placed before the House, you will have an opportunity to speak against it. You achieve nothing and are, in fact, out of order if you try to make a substitute motion which is the opposite of the main motion.

Tangential substitute motions are generally not germane, and when they do qualify, they frequently contribute to misunderstanding and cloud the principal issue of the pending business. On the other hand, an amendment can strengthen a main motion by adding the better idea or otherwise assisting in the implementation process.

Your Speakers will continually remind you of your rights and privileges as members of a parliamentary body. When necessary, we will rule, making a sincere effort to call the play fairly, impartially, and quickly. We are not infallible, and the remedy of challenge is always available to you. To this extent, we will be apart from the decision-making process, unless, of course, your equal division places one of us in the posture of being forced to cast the deciding vote. This, we assure you, will be a duty which we will perform only after a recorded division of the House by our Tellers.

In recent months, many physicians have come to the conclusion that the business of medicine has gained new and urgent importance. Some even suggest that the scientific work of our annual session be reposed in the hands of the specialty societies or assigned to the serious learning climate of the major medical center. Almost without exception, these opinions have urged new emphasis upon the work of policy decision, in-depth discussion of socioeconomic matters, and of the delivery system. This is our opportunity to deliver the goods for these colleagues with thoughtful discussion, constructive deliberation, and prudent decision.

Let us as delegates, the fiduciaries of the policy under which our association shall be guided, listen, learn, inquire, discuss, contribute, and decide to the end that our performance is worthy.

Let none forget that what we do here carries forceful impetus. For example, a resolution in 1970 from the East Mississippi Medical Society on limited licensure of foreign medical graduates is now on the statute book as the most significant amendment to the Medical Practice Act in a generation.

Let us also understand that what we fail to do or what we do poorly may have similar widespread effect. This should underscore the weight of responsibility upon us.

Among the many here with prior experience and years of service are new and capable House members. We will work as a team with a common purpose of serving our patients, our state, and our profession. Your Speakers pledge you our best. Let us be about our work toward these good ends.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

The reference committee appreciates the remarks of our unavoidably absent Speaker, Dr. William E. Lotterhos, which were ably presented to us by the Vice-Speaker, Dr. John B. Howell, Jr. of Canton. We thank Dr. Howell and Dr. Stanley A. Hill, the Speaker *pro tem,* for their fair and impartial and efficient conduct of our business in the House of Delegates. We thank Dr. Lotterhos for his constructive remarks which we approve and recommend adoption by the House of Delegates.

The report of the reference committee was adopted.

PRESENTATION OF DISTINGUISHED GUESTS

The Speaker presented the following distinguished guests:

Dr. Porter Fortune, Oxford, Chancellor of the University of Mississippi.

Dr. J. E. Johnson, Memphis, Chancellor, University of Tennessee Medical Units.

Dr. Alton B. Cobb, Jackson, Director, Mississippi Medicaid Commission.

Mr. Charles L. Mathews, Jackson, Deputy Director, Mississippi Medicaid Commission.

Mr. W. C. Moseley, Jackson, Vice President, Mississippi Hospital and Medical Service.

Mr. Sam Cameron, Jackson, Assistant Director, Mississippi Hospital Association.

Mrs. Louis Lehmann, Natchez, Past President, Woman's Auxiliary to the Mississippi State Medical Association.

ANNOUNCEMENT OF THE NOMINATING COMMITTEE

Following a recess for caucuses by association districts, the Nominating Committee was announced:

Walter H. Rose, Indianola, District 1.
John R. Lovelace, Batesville, District 2.
William H. Preston, Jr., Booneville, District 3.
Edward Pennington, Ackerman, District 4.
Tom H. Mitchell, Vicksburg, District 5.
Norman W. Todd, Newton, District 6.
James M. Dabbs, Waynesboro, District 7.
Sidney O. Graves, Natchez, District 8.
James T. Thompson, Moss Point, District 9.

Dr. Thompson was elected chairman of the committee which conducted an open meeting on May 5, 1971, and posted the nominations for the

information of all members in addition to submitting a written report of nominations to the House of Delegates.

ADDRESS OF THE PRESIDENT

The Speaker declared the House of Delegates in open session, and the President, Dr. Paul B. Brumby, delivered his address. The address has been published separately in Volume XII, Number 7, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, July 1971.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

We applaud and commend Dr. Paul B. Brumby of Lexington, our 1970-71 President, who has served us with diligence, dedication and enthusiasm. We appreciate his address to the House of Delegates and we ask that this be published in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION. In approving his address we thank Dr. Brumby and wish him well as he continues his service to our association and medicine.

The report of the reference committee was adopted.

SPECIAL ADDRESS

Dr. Walter C. Bornemeier of Chicago, President of the American Medical Association, addressed the House of Delegates as the principal speaker of the 103rd Annual Session.

REPORT OF THE DELEGATES TO AMA

Your delegates to the American Medical Association, in conformity with custom and past practices, have limited their joint report to this House of Delegates to key policy actions at the annual and clinical conventions. Because of the comprehensive reporting in the *American Medical News* and *Journal AMA* of scientific and subsidiary activities, further reporting of these aspects of the AMA conventions would constitute needless duplication and repetition.

Dr. G. Swink Hicks of Natchez entered upon his second full term Jan. 1, 1970. Following the resignation of Dr. Howard A. Nelson of Greenwood in May 1970, President Brumby appointed Dr. Stanley A. Hill of Corinth to serve the unexpired term. Dr. Hill was seated at the Chicago annual and Boston clinical conventions. To serve Dr. Hill's unexpired term as alternate delegate, President Brumby appointed Dr. C. D. Taylor, Jr., of Pass Christian. Dr. Taylor, elected delegate to AMA at the 102nd Annual Session, entered upon his first term on Jan. 1, 1971. Dr. Hill, re-elected alternate delegate, has entered upon his new term of service. Dr. Joseph B. Rogers of Oxford continues to serve as Dr. Hicks' alternate.

This reporting covers the 119th Annual Convention at Chicago, June 21-25, 1970, and the 24th Clinical Convention at Boston, Nov. 29-Dec. 2, 1970. Your delegation is indebted to our president and other officers and members who participated in these conventions and worked with us. When, on the final day of the Boston clinical convention, it was necessary for Dr. Hicks to return to Mississippi for an important meeting of the State Board of Health, Dr. S. Jay McDuffie of Nettleton, was certified and seated as substitute delegate, as provided for in the AMA By-Laws.

Chicago Annual Convention. The House of Delegates considered 201 items of business during more than 17 hours of meetings, not including time spent in reference committee hearings. The Board of Trustees submitted 31 reports, and there were 30 others from various councils and committees. A total of 140 resolutions were introduced, including 27 relating to the Report of the Committee on Planning and Development (Himler Report).

Among all issues considered, none was more sharply debated than the now-well-known policy position on abortion:

"Resolved, That abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only in conformance with standards of good medical practice, and after consultation with two other physicians chosen because of their professional competence, and within the Medical Practice Act of his state; and be it further

"Resolved, That no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

Prior to the Chicago convention, wide publicity had been given a dues increase decided upon by the Board of Trustees. The proposal was an increase to $150 per year from $70. The House voted an increase to $110 per year, and removed from the authority of the Board the dues-fixing prerogative by amendment of the By-Laws. Unlike our state medical association where the House of Delegates has always possessed the dues-setting authorities, the AMA By-Laws pre-

viously permitted the Board to do this, thus requiring the House to accept or reject the decision.

Most state association delegations had instructions on the controversial Himler Report, and 27 resolutions were introduced in connection with it. The matter was, in effect, put to rest by three actions: Creation of a standing body of the House of Delegates designated the Council on Long-Range Planning and Development, extensive revision (and in many instances, deletion) of the controversial recommendations, and recommital of the report to the new body. This has resulted in the Himler Report having been removed from implementation and requires that any further matter within or arising from it be submitted to the House of Delegates by the new council of the House.

The concept and format of formal postgraduate medical education were altered by what amounts to elimination of the internship. The action requires that no new internship program be approved after July 1, 1971, unless it and a related residency are organized and conducted as a unified and coordinated whole. From and after July 1, 1975, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education.

Professional liability insurance, a critical matter in at least half of the states, especially in the west, was the subject of special reports and resolutions. The Board reported that it was exploring the possibility of instituting a joint AMA-state medical association program which would be optional with states.

Allied professional personnel, particularly nurses, were considered as well as their respective definitive roles in patient care, training, and postgraduate or continuing education. A number of separate but related actions were taken on hospitals as regards the requirement of the Joint Commission on Accreditation of Hospitals as to records-keeping and staff privileges and responsibilities. The House reaffirmed the AMA position that general practitioners should have the opportunity to practice medicine as active staff members in hospitals and should be granted privileges commensurate with their training and demonstrated abilities. It was also recommended that medical staffs consider revising their respective hospital medical constitutions and by-laws to differentiate clearly between medical and administrative duties.

The House approved a Board proposal to establish a wholly owned separate subsidiary corporation to engage in publication and possibly other related activities for purposes of economy. Approval was given to a communications program which would consist of television documentaries, educational advertising, media relations, and other activities to improve public understanding and opinion of the profession. The cult of chiropractic was again condemned, and the Judicial Council ruled that it is not unethical for a physician to own an interest in a for-profit hospital unless such ownership or interest is misused. The House was critical of present methods of reporting infant mortality, particularly by comparing statistics for the United States unfavorably with other countries which employ different criteria.

Dr. Wesley W. Hall of Reno, Nev., was elected president-elect, and your delegation had the privilege of being the first to second the nomination. There were no disruptions of the House by demonstrators and radical elements because of drastic security precautions.

Boston Clinical Convention. Principal actions at the clinical convention included government-sponsored health programs, medical education, policy on abortion, membership, peer review, and allied professional personnel.

President Bornemeier urged the profession to assume a role of leadership in health care delivery, even to instituting innovations such as neighborhood clinics and sponsorship of government programs. He reiterated his proposal for compressing the medical education process to six years with strong supportive postgraduate or continuing education programs.

Although there was reason to believe before the convention that the policy on abortion would be the subject of long and possibly bitter debate, the House reaffirmed the policy adopted at Chicago with brief discussion. A new classification of direct membership for interns and residents was approved. Dues prescribed are $20 annually, and membership must be converted to active or service after completion of training. The action is not mandatory, however, upon state medical associations already providing membership opportunity for interns and residents under dues exemptions, as has historically been done by our association.

The House reaffirmed its approval of physician-conducted peer review and the concept of Peer Review Organization (PRO) as contained in the AMA Medicredit bill. The House received information that the AMA had secured a number of desired changes in the then-pending Bennett Amendment to H.R. 17550: Deletion of pre-admission approval; no federal ownership of PSRO files; and removal of punitive fines.

The Judicial Council restated the "age old professional ideal of medical service to all, whether able to pay or not," and the House reaffirmed it. The recommendation was made because of many letters complaining of an apparent preoccupation by an increasing number of physicians with the financial aspects of their medical practice." AMA officially abandoned use of the terms "ancillary" and "paramedical" in official statements, using instead "allied." The House approved a recommendation from the Board calling for a moratorium on further licensure of new groups of allied professional personnel, pending further study and clarification of training and roles in patient services. The House rejected changes in the manner in which AMA Trustees are elected.

In other actions at Boston, the House urged improvement of outpatient coverage under insurance, voluntary prepayment, and government financing programs. The MECO project of summer externships for medical students was endorsed with the request that state medical associations assist.

An unwarranted, unpleasant, and untoward incident occurred at the annual medical service conference on Nov. 28 which immediately preceded the convention. An intern on the program who has been prominently associated with OEO-sponsored community action health programs in Mississippi made certain untrue assertions about the state of health care and medical licensure in our state. Your delegation protested these utterances to the AMA leadership.

Dr. Hicks presented a statement and read it into the record in the House of Delegates on Dec. 2 in which the charges were refuted. The chairman of the Michigan delegation, Dr. Donald Sweeney, endorsed Dr. Hicks' statement, and the House of Delegates voted to append it to the record of the medical service conference. It is also a matter of permanent record in the proceedings of the House of Delegates.

Expression of Delegates. Your AMA Delegates express their appreciation to our own House of Delegates, to the Board of Trustees with whom we sit at all meetings, and to the general officers for support, assistance, and continuing communication so that we may be properly prepared to represent your wishes and policy positions.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Dr. G. Swink Hicks of Natchez, our senior delegate, and Dr. Stanley A. Hill of Corinth who was called to service as a delegate from his alternate status following the resignation of his principal, Dr. Howard A. Nelson of Greenwood, have represented us well at the 1970 annual and clinical conventions of the American Medical Association. We appreciate and approve the concise report given us by Drs. Hill and Hicks and recommend its adoption as we thank them for their service.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

102nd Annual Session. At the 102nd Annual Session in 1970, the House of Delegates approved three amendments to the By-Laws of the association:

Section 3, Chapter X, was amended to abolish the former Grievance Committee and establish the Committee on Peer Review as a constitutional body having nine members, one from each association district, appointed for terms of three years each. The duties of the committee are prescribed.

Section 4(a), Chapter I, was amended to provide exemption from state medical association dues for those members who have attained age 70, who have been in good standing for any 10 consecutive years. This exemption becomes effective on request by the member on Jan. 1 after the 70th birthday and continues so long as the member is in good standing in his component medical society.

Section 7, Chapter IX, was amended to increase the membership of the Council on Budget and Finance to five members from three members, the amendment to become effective at the 103rd Annual Session to provide for orderly arrangement and succession in the terms of the members of the expanded council.

Pending Amendment Proposal. On the concluding day of the 1970 annual session, Resolution No. 15, subject: Conduct of the House of Delegates, was introduced by Dr. Howard A. Nelson of Greenwood. This resolution proposes that Section 4, Chapter V, By-Laws of the association be amended to delete *Robert's Rules of Order, Newly Revised* as the parliamentary standard of the House of Delegates and substitute therefor *Sturgis Standard Code of Parliamentary Procedure.* The resolution shall have lain on the table for one year, and hearings on it and other business which may be brought before the council will be conducted on the afternoon of May 3.

There are no pending amendments to the Constitution.

The report of the council was received for information.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties. The Council on Scientific Assembly is a constitutional body of the House of Delegates, charged with the responsibility of planning the annual session of the association to include all scientific activities, programming, and the scheduling of annual session events. The council membership consists of the chairmen and secretaries of the seven scientific sections and the secretary-treasurer of the association, a total of 15 members.

103rd Annual Session. Planning and organization of the 103rd Annual Session was initiated in the summer of 1970. The format suggested in the By-Laws and approved by the House of Delegates has been continued with general sessions centered around broad areas of specialty interests. To the maximum possible extent, conflicts in schedules and programming have been eliminated, although as a practical matter, such total elimination is not possible. In many instances, the council has requested and placed essayists from various specialty societies not represented in the Scientific Assembly before section audiences.

We are gratified that at the present annual session, 12 specialty groups have related or concurrent meetings with us. Four medical alumni groups have fraternal and social occasions, and various nonscientific but medically related bodies will meet during May 2-6. We continue to believe that providing for and encouraging these related meetings increases the attractiveness of the annual session to the membership and benefits attendance. We are glad to continue support of the Woman's Auxiliary and its concurrent annual session with us.

The morning scientific motion picture programs have been discontinued because of poor attendance. Only the mid-day programs have been scheduled. We are gratified with the presentations in the scientific exhibit, and we urge every member and guest to view these and the Technical Exhibits.

Technical Exhibit. Your council notes that ethical pharmaceutical firms, suppliers, and others eligible for purchase of space in our Technical Exhibit are declining our invitation to participate in growing numbers. This is not confined to Mississippi, because other state medical associations, major state specialty societies, and national organizations are having the same experience.

Harsh federal drug legislation, changing concepts in marketing, and tighter budgets for advertising are taking a toll of technical exhibit revenues. We have circularized more potential exhibitors than ever before, yet our present exhibit is one of the smallest in history. We continue to do all things possible to increase this participation.

Annual Session Funding. The Council on Budget and Finance and the Board of Trustees have requested your council to make the annual session financially self-sustaining. Appropriations for honoraria in the Scientific Exhibit were reduced by the Board to $300 for this annual session. Other economy measures have been instituted, including discontinuation of the annual association dinner-dance which experienced declining attendance. Instead, an association-wide cocktail party will be conducted which includes no dinner or entertainment. The admission assessment is accordingly decreased to a modest level to meet costs.

We cannot, however, guarantee that the present annual session will be financially self-sustaining, because revenues from exhibit sales are down, and many expenses necessary to minimum operations have increased with inflation. The management of the annual session is being accorded the closest attention by your council and the executive staff.

Headquarters Hotel. For about 20 years, the annual session has been conducted in two major Mississippi convention hotels. After 1968, the site was permanently moved to the Gulf Coast until convention facilities in Jackson were improved. After the 102nd Annual Session in 1970, your council requested the Board of Trustees to appoint a survey committee to examine other convention facilities on the Gulf Coast and make recommendations, since the Board recommends sites and dates for action and decision by the House of Delegates.

A committee consisting of our immediate past president, your council chairman, and a section officer from the Gulf Coast was appointed. As a result of its survey, the Board made the decision to terminate contracts with our former headquarters hotel and move the present annual session to the new Sheraton-Biloxi.

Expression of the Council. Your Council on Scientific Assembly is grateful for the support, cooperation, and assistance we have received in planning the 103rd Annual Session. We are aware that there will be problems in the new facility, both from the hotel as it adjusts to the massive task of servicing a complex convention and from us as we try to adapt to the new building and convention staff. We ask the help and understanding of all registrants toward the end that our annual session may be personally enjoyable and professionally profitable.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

We approve the report of the Council on Scientific Assembly and we warmly commend each of the fifteen members for the splendid program which has been prepared for us at our 103rd annual session. We further commend the council on the selection of the excellent hotel facilities and for the thorough preparations made for the annual session. We recommend that the Council on Scientific Assembly consider reestablishing the annual association banquet on Wednesday evening.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties. The Council on Medical Service is a constitutional body of the House of Delegates, consisting of nine members, one from each association district, elected for terms of three years each. There are three *ex officio* members who are our president, president-elect, and secretary-treasurer. The council is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under the council's jurisdiction are assigned activities of the association in medical service, emergency service programs, medical care for the indigent, and the work of allied medical agencies and organizations.

The council is assisted in its work by five committees, four constitutional and one *ad hoc,* all of which have conducted formal programs and activities during the 1970-71 association year. These embrace a wide range of subject areas in our purview of responsibility, including maternal and child care, mental health, occupational health, blood and blood banking, and nursing.

Mental Health. The chief concern this year has been with drug addiction and drug abuse. Our program of supplying information to physicians and the public on drug abuse has been increased, and a special kit of professional information, including reprints of scientific articles, policy statements, brochures, and suggested speeches, has been produced and furnished on request.

The community mental health center program has progressed with new and additional construction in the nine districts of the state. A major objective of the association was realized with the decision of the State Building Commission to construct the retardation center at Oxford, as voted in 1970 by the House of Delegates, and with the action of the 1971 Regular Session of the Legislature in funding construction and equipping.

At the time of preparation of this report, legislation is pending to formalize into statute the Interagency Commission on Mental Illness and Retardation. The association has supported this agency and the overall objectives of extending care for mental illness and retardation.

The chairman of the Committee on Mental Health, Dr. John J. Head of Jackson, resigned because of personal health and his retirement. The council commends Dr. Head for his leadership in this important area over the years.

Committee on Occupational Health. A major program of this committee is development of guides for occupational health programs in small plants in Mississippi, and individual members continue to prepare editorials and scientific articles for publication in the JOURNAL. A major deficit in state workmen's compensation statutes is lack of definition of injury and extent of coverage.

The committee has reviewed ongoing efforts in the 1971 Regular Session of the Legislature with reference to amendments to the workmen's compensation statutes. At the time this report was prepared, various bills were pending, both in committee and on calendars.

Dr. George D. Purvis of Jackson has submitted his resignation as chairman after serving 15 years. Your council commends his exercise of leadership, valuable contributions to the work of our association in this area, and his able representation of us before local, state, and national groups.

Maternal and Child Care. The continuing maternal death studies have been conducted by our committee and are now in the 14th year. A 10-year report on the studies will soon be published, and individual members regularly prepare case reports for publication. All of the study data are now computerized, and the committee has conducted and published substudies on anesthesia deaths and hemorrhage.

The committee has continually reviewed legislative activities of interest within its field and has given valuable consultation in connection with the abortion amendments before the Legislature. Pertinent court decisions are also reviewed.

The chairman of the committee is Dr. William B. Wiener of Jackson. The committee consists of seven members, and three consultants in the fields of pathology, anesthesiology, and internal medicine assist.

Blood and Blood Banking. The committee is developing systems model for blood assurance and blood inventories programs which may be

initiated on a pilot basis within a year. This would consist of computerized information centered around blood banks and blood assurance programs as to individual and family participation.

To assist in focusing attention on the urgent need for blood donors, the committee acted to secure a proclamation from the Governor proclaiming January 1971 as State Blood Donor Month. President Nixon issued a similar proclamation on National Blood Donor Month. A special commemorative postage stamp was issued in March in this same connection.

The committee has been deeply concerned about the *Cunningham* decision in Illinois where a hospital was liable for untoward effects of a blood transfusion, even though no negligence was involved. This was the first instance of application of strict tort liability to blood service. The committee noted that some legal authorities feel that our Mississippi statute stating that blood transfusions are a service and not a sale is no longer sufficient protection against this new legal doctrine.

At the time this report was prepared, remedial legislation providing immunity from strict tort liability (in the absence of negligence) had passed the House of Representatives in the Mississippi Legislature and was pending before the Senate.

Dr. Kenneth M. Heard of Jackson is chairman of this committee.

Nursing. The committee conducted extensive activities in 1970 with reference to mandatory licensure for nurses. The measure was passed by the Regular Session, and the association's policy position, adopted at the 102nd Annual Session was:

(1) The association supports mandatory licensure of nurses in principle, reserving the prerogative of making further changes and improvement and further reserving to the Board of Trustees final approval.

(2) The Committee on Nursing be utilized in consultation and testimony before the Legislature within the framework of policy because of the committee's familiarity and expertise in the matter.

The committee chairman has served as the association's representative on the nurse education advisory body to the Board of Trustees of Institutions of Higher Learning and on a special study group of that body charged with reviewing nurse education programs.

The committee takes the position that there should be no further licensure of allied health professions pending study and clarification of their respective roles in health care delivery. This is the position of the American Medical and American Hospital associations.

Active liaison is maintained with the Mississippi Nurses Association, and regular joint meetings with our committee are conducted.

The chairman is Dr. Tom H. Mitchell of Vicksburg.

Medicaid. Oversight of the Medicaid program as regards our association's interests was assigned to your Council on Medical Service. During September-December 1970, a special study on views of practicing physicians on Medicaid in Mississippi was prepared for the General Legislative Investigating Committee of the Legislature. The study report was released Jan. 4, 1971, immediately after publication Jan. 1 in the JOURNAL. Subsequently, the investigating committee furnished a copy of the study to each Senator and Representative.

The data were determined from 689 usable replies to the survey which inquired into three areas of concern among practicing physicians of Mississippi with reference to Medicaid:

(1) Physician participation.

(2) Fees paid.

(3) Comment, suggestions, and recommendations.

With reference to participation, we found that three out of four Mississippi physicians state that they participate in Medicaid by accepting patients and filing claims.

One out of five does not participate.

One out of six has participated but does not participate now.

One out of 12 has never participated.

Half of the physicians who do not participate in Medicaid give low fees paid as the reason.

A third of the nonparticipants say the reason is too much paperwork.

One out of nine is opposed to Medicaid.

A few submitted specific reasons for not participating, including slowness of payment.

A number of recommendations came from respondent physicians:

(1) Reduce paperwork for practicing physicians in preparing, filing, and reporting on claims.

(2) Pay better professional fees, preferably under the concept of usual and customary fees.

(3) Eliminate abuse of the program by patients.

(4) Relieve limitations imposed on the amount of medical care needed by the patient.

(5) Process and pay claims promptly.

(6) Eliminate dual claims procedure in Medicare crossover.

We found that more medical than surgical specialists participate in Medicaid. Eight out of 10

nonsurgical specialists participate, whereas two out of three surgical specialists participate. Areas of highest participation by physicians tend to appear with the highest impaction of recipients and major medical centers with the exception of East Mississippi and the Gulf Coast.

Medicaid Legislation. Growing out of the study was a measure for a substantial increase of professional fees under Medicaid, authorizing payment at the rate of the Blue Shield F-450 schedule from the present F-300 schedule. At the other extreme, the chairman of the House Appropriations Committee, Hon. Edgar Stephens of New Albany, also a member of the Medicaid Commission, introduced a bill to freeze physicians' fees for services under any state health program at $4 per unit on the 1964 California Relative Value Index. Both bills died without action in the Regular Session. The program is funded at about $41 million for fiscal 1972.

PMM Comprehensive Health Planning Report. The Division of Comprehensive Health Planning retained the services of Peat, Marwick, Mitchell and Co., a national accounting and management counsel firm to conduct a study on organization structure for publicly supported health activities in Mississippi. The report recommended a single commission with seven members, none of whom could be health professionals. Altogether, the plan would consolidate 20 budgeted entities consisting of 30 operating agencies into the single commission.

In this process, the State Board of Health would have been abolished, and all professional licensure, i.e., physicians, dentists, nurses, pharmacists, psychologists, etc., would have been placed under a single office of the commission. County health departments would have likewise been abolished in favor of 10 regional public health centers or units.

Legislation to implement the recommendations consisting of a series of bills considerably modified from the PMM recommendations *per se* was introduced before the Regular Session. One measure would have abolished the Board of Health and reconstituted a board of 11 members with only one physician. Medical licensure would have been removed to a separate medical board of examiners.

Other legislation introduced but not related to the PMM report would have renamed the Board of Health and divested it of medical licensure responsibilities. All such legislation was unsuccessful.

A special committee of the council considered the PMM report and met with representatives of the Division of Comprehensive Health Planning.

Expression of the Council. The council expresses special appreciation to its committees, some of which are among the most active working bodies of the association, and to our colleagues of the Board of Trustees who work closely with us. We deeply appreciated dedication of the third executive in our Central Office to the work of medical service, and we ask that he be replaced to continue to furnish urgently needed staff services for our programs.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

We commend the Council on Medical Service for its substantial work in our behalf and for its varied and versatile program which is carried on through four constitutional and one *ad hoc* committees. These include Mental Health, Maternal and Child Care, Occupational Health, Blood and Blood Banking, and Nursing. We commend and approve the work of the council in making a study of physician participation in Medicaid for the Mississippi Legislature and for providing the Mississippi Medicaid Commission with valuable information in this connection. We approve the report of the Council on Medical Service and recommend its adoption by the House of Delegates.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT A OF THE COUNCIL ON MEDICAL SERVICE

In early 1970, Gov. John Bell Williams appointed a 40-member Committee on Children and Youth consisting of professional individuals and knowledgeable nonprofessionals and community leaders. The chairman appointed by the Governor is Dr. William E. Lotterhos of Jackson.

Working through four task forces which were respectively assigned study responsibilities in the areas of health, education, social factors, and laws, the committee amassed, coordinated, and published a valuable study entitled "The Needs of Children in Mississippi."

Your council recommends that the House of Delegates receive the study and direct appropriate referrals of portions pertinent to the medical profession to official bodies of the association for implementation within the framework of association policy.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Supplemental Report A of the Council on Medical Ser-

vice pertaining to the work of the Governor's Committee on Children and Youth. We appreciate receiving the report of this committee which was chaired by Dr. William E. Lotterhos of Jackson. We recommend approval of the Supplemental Report and its referral, together with the report of the Governor's committee, to the Board of Trustees for further study and referral to various official bodies of the association which are concerned with these several separate subjects in the report.

The report of the reference committee was adopted.

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties. The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with the duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties, the Board shall have conducted six meetings in 1970-71 consisting of 12 meeting days since the 102nd Annual Session.

Seven officers sit with the Board of Trustees at all meetings. They are the president, president-elect, secretary-treasurer, speaker, vice speaker, and the two AMA delegates. The Board is assisted in its work by support of the executive staff. All 1970-71 meetings were conducted at Jackson.

This annual report includes actions on matters referred to the Board by the House of Delegates and items relating to management and policy functions which are among the Board's responsibilities.

Referrals from the House of Delegates. Matters referred to the Board of Trustees at the 102nd Annual Session and actions by the House requiring further actions by the Board include:

(a) *Resolution No. 2.* This resolution requires that we seek amendments to the abortion law permitting therapeutic abortion on written consultation by two reputable physicians where continuation of the pregnancy constitutes a threat to the health of the patient, when the pregnancy results from incest, and for fetal considerations. The present law permits the procedure where a threat to the life of the patient is found and when the pregnancy results from rape. The resolution requires that the latter be defined in statute as "forcible" or "statutory." A suitable bill was prepared and introduced in the 1971 Regular Session of the Legislature but it died on the calendar in the House of Representatives. A bill which would have permitted abortion on demand was opposed by the association and killed in committee.

(b) *Resolution No. 3.* This resolution calls for authorizing limited licensure for selected foreign medical graduates for service in state medical institutions. A bill was drawn and introduced in the 1971 Regular Session. The measure passed both chambers and has been signed into law by the Governor.

(c) *Resolution No. 4.* This resolution requires the seeking of legislation which would require all who (are licensed henceforth) hold themselves out to diagnose and treat human illness to meet the same standards of education and training as doctors of medicine. After repeated meetings with the Attorney General, we found that implementation of the resolution would involve as many as five separate bills amending the Medical Practice Act. Failure of any one bill could have resulted in a legislative disaster, and the decision was made to withhold further action, especially in view of the defeat of efforts in both the House and Senate to license chiropractors. The Board of Trustees requests additional time in which to study means of implementing the resolution without endangering any aspect of the Medical Practice Act.

(d) *Resolution No. 6.* This resolution amended Section 4(a), Chapter I, By-Laws of the association, to provide exemption from dues for members who have attained age 70 and have been members of the association for any 10 consecutive years. Announcement of the amendment has been made to the membership through the JOURNAL and in writing to secretaries of component medical societies. The Executive Secretary informed each component medical society secretary of this new provision, and 12 of 29 eligible members have availed themselves of this dues exemption benefit at the time of preparation of this annual report.

(e) *Resolution No. 7.* This resolution calls for relief for physicians from burdensome procedures and paperwork in filing claims under the Mississippi Medicaid program. Soon after adoption, the Medicaid Commission simplified the physicians' claim form and undertook to provide for elimination of the Medicare claim crossover double filing. In late 1970, the association performed a study for the General Legislative Investigating Committee on views of practicing physicians on the program. The point of the resolution was reemphasized as well as additional views elicited in the study.

The Medicaid Commission has demonstrated interest in improvement of administrative aspects of the program and has addressed itself directly to matters contained in Resolution No. 7. The

Board anticipates improvements in the program and will continue to work for objectives stated in the resolution and in previous policy.

(f) *Resolution No. 10.* This resolution is concerned with association financial management and is reported elsewhere in this annual report.

(g) *Resolution No. 11.* This resolution concerns support for Project CARE-SOM, the emergency medical helicopter services based at Greenwood, Jackson, and Hattiesburg. Support for the service was first given by the association through Gov. Williams' office and later, during the 1970 Regular Session of the Legislature. We supported House Bill 250 and Senate Bill 1903 permitting two or more counties to organize an air ambulance district, lease or acquire aircraft, provide for operation, maintenance, and crews, and conduct necessary communications activities. The effort was successful.

(h) *Resolution No. 12.* This resolution seeks federal tax credit for practice in a rural area. While the Board supports the resolution and principle, the Congress has been unresponsive in amending the Internal Revenue Code 1954 to accomplish this purpose. Other incentives, including enactment of a measure by the 91st Congress permitting draft-eligible physicians to elect to serve in rural and inner city areas in lieu of military service, offers much encouragement in relieving the problem which was addressed in the resolution. The association has initiated two positive programs in this connection: (1) publication of a new and expanded Physicians Placement Bulletin in partnership with the Ole Miss Medical Alumni Association and (2) intensified effort to improve rural medical service by the Council on Medical Service. Additionally, Sen. James O. Eastland has introduced legislation to assist in locating physicians in rural areas.

(i) *Resolution No. 13.* This resolution seeks to increase the supply of physicians in Mississippi by additional support for the University of Mississippi School of Medicine. The Board is glad to report that the University will accept its largest beginning class in 1971, consisting of 95 freshmen. The association has supported increased appropriations for the medical school and has offered other good offices where and when support may be given.

(j) *Resolution No. 14.* This resolution urged that the state locate and construct the institution for the mentally retarded at or near Oxford. Immediately following the 102nd Annual Session, the resolution was transmitted to the Governor, the Board of Trustees of Mental Institutions, the State Building Commission, and the Interagency Commission on Mental Illness and Retardation. Representatives of the association met with state officials and presented the recommendation. On July 9, 1970, it was announced that the facility would be constructed at Oxford.

Nominations for the State Board of Health. No vacancies on the State Board of Health occurred in 1970, and it was therefore unnecessary for the House of Delegates to make nominations to the Governor at the 102nd Annual Session. Acting on nominations made in 1969 at the 101st Annual Session, Gov. Williams made the following appointments for six year terms: Public Health District, 2, Dr. G. Lacey Biles, Sumner; Public Health District 4, Dr. S. Lamar Bailey, Kosciusko; and Public Health District 5, Dr. Lamar Arrington, Meridian.

CHAMPUS. The association concluded its 14th year as fiscal administrator for the CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) program in Mississippi. The operation continues to grow with an increase in claims volume of 20 per cent and a dollar volume increase of 25 per cent in 1970, and it is a multimillion dollar operation. Compensation to physicians for professional services is made under the concept of usual and customary fees under medical peer control.

Less than 6 per cent of claims received are such that they are reviewed by the five-member review committee. Payment to physicians and others is made weekly. In January 1971, the Department of Defense severed the program from HEW regulations as to usual and customary fee determination, and payment is made solely on profiles of charges by Mississippi physicians.

JOURNAL MSMA. The JOURNAL has concluded its 11th consecutive year of continuous publication in 1970. It remains the largest single association-sponsored project and is a team effort among the Editors, Committee on Publication, and JOURNAL staff. The Board expresses appreciation to the Editors and committee in the production of this vital membership service.

Insurance Programs. There are approximately 2,100 contracts among 1,450 members in the association's two major group insurance programs. In addition to the Blue Cross hospitalization group, the association sponsors general accident, disability, health, and life programs with the Continental Companies and a professional liability insurance program with the St. Paul Companies. The association handles no premium collections nor processes claims. The Board takes the position that any profits or payments which might

thereby accrue to the association should be passed along to participating members in the form of lower premiums or greater benefits.

About 1,400 contracts are in force in several Continental groups which are administered by the Thomas Yates Co. of Jackson, and the participants constitute more than 40 per cent of the membership.

There are about 700 participants in the St. Paul professional liability insurance program. We enjoy the fourth lowest premium rate in the United States, largely as a result of our carefully managed and monitored program under which claims review is available to any member against whom a claim or suit is threatened or initiated. The Board commends this program to physicians, pointing out its substantial monetary benefit in savings to members. The professional liability market has become a critical matter for most American physicians.

The Board urgently recommends that each member exercise care and diligence in securing this vitally necessary coverage and that threatened or instituted litigation be brought before the Board. We are not immune in Mississippi from the crisis in liability litigation which has come to so many states.

Himler Report. A major issue at the 102nd Annual Session was the Himler Report or Report of the AMA Committee on Planning and Development. The report contained many drastic departures in policy and medical practice pattern recommendations. Because of its drastic nature, the Board of Trustees made the decision to transmit the report in full text to the membership through the JOURNAL and to the House of Delegates.

In extended debate, the House of Delegates made the decision to divide the report into three categories: Those portions which merely reiterate previously approved policy; those which recommend information gathering; and those which are frankly controversial. The House directed that a special committee or task force be appointed to deal with the report.

Further study, debate, and consideration were given the report and directives of the MSMA House of Delegates by the Board of Trustees which chose to constitute itself as the monitoring task force. In the meanwhile, other state medical associations took similar actions as opposition to controversial portions of the report mounted. At the AMA annual convention at Chicago in June 1970, the House of Delegates acted to recommit the report which had the effect of indefinite postponement. While the constitution of the Board as the special committee has thus become moot, the Board continues to monitor all developments in this connection. Moreover, the report has been communicated in full text to every member of the association. The Board recommends that no further action be taken.

Bicentennial of the United States. In 1976, the nation will observe its bicentennial, and appropriately, the AMA will conduct its annual convention at Philadelphia, the city in which the Declaration of Independence was signed. The City of Philadelphia and the Philadelphia Medical Society will construct a building to house a permanent Historical Museum of American Medicine, and our association has been invited to contribute a permanent exhibit on Mississippi medicine. The Board has considered something related to the work of Dr. Joseph Goldberger who discovered the cause and cure for pellagra at Jackson, 1912-14. The Board invites the membership to suggest other exhibits.

The Board reminds the House of Delegates that Philadelphia is the site of the first medical school in the United States and that the first graduate was a Dr. John Archer. Our 1964 president, the late Dr. John G. Archer of Greenville, was the fifth direct lineal descendant of the first American-trained physician.

In addition, the most distinguished museum in the nation, the Smithsonian at Washington, will present an exhibit in 1976 on American medicine as part of the Bicentennial observance. We have also been invited by the Smithsonian to participate in this project, lending or contributing some artifact representing Mississippi medicine.

Legislative Program. In 1970, the House of Delegates directed, in response to a special report of the Board and the address of our then-president, Dr. James L. Royals, that a new and intensive legislative program be developed and implemented. This consisted of production of a new weekly legislative newsletter, monthly meetings of the Council on Legislation during sessions of the legislature, regular meetings with key committees of the House of Representatives and Senate, daily staff representation at the Capitol, continuation of the Emergency Medical Care Unit at the Capitol, and doctor-to-legislator communications.

This program has been implemented, and the new "Mississippi Medical Legislative Report," a four-page weekly newsletter, has been furnished by first class mail to all members. The Council on Legislation initiated monthly meetings during which conferences are held with the public health committees of both chambers. The association has presented testimony, both oral and written, on a number of occasions, and our executives have

represented us daily at the Capitol. The Board commends the Council on Legislation for developing and implementing this program.

Budget and Finance. Resolution No. 10, adopted in 1970, expanded the Council on Budget and Finance to five from its present three members, broadening the base of association financial management. Other actions corrected our procedures for preparation and approval of the annual budget by the council so as to observe fully the requirements of the By-Laws on our calendar fiscal year.

In accordance with Resolution No. 10, the Board has provided for orderly succession of the new members of the council, as outlined in the Report of the Secretary-Treasurer on vacancies in office. The council met in December 1970 and prepared the 1971 budget which was presented to the Board of Trustees in accordance with established procedures. The fiscal program shall have been reviewed by the Board in April, and the budget will be presented to the House of Delegates in the customary manner.

Both the Council on Budget and Finance and the Board of Trustees are gratified with this improvement which gives our growing operations and fiscal program a broader base of management selected by the House of Delegates and effectively corrects the lag in development of the annual budget.

Appointments. Under the provisions of Section 1, Chapter VII, By-Laws of the association, the appointive powers are vested in the president. During the 1970-71 association year, President Brumby made the following appointments and nomination, each of which has the endorsement of the Board of Trustees:

(a) *Delegates to AMA.* Following the resignation of Dr. Howard A. Nelson of Greenwood as Delegate to AMA, Dr. Stanley A. Hill of Corinth, then serving as Alternate Delegate to AMA, was appointed to serve the unexpired term through Dec. 31, 1970. In this capacity, Dr. Hill represented the association at the Chicago annual convention and the Boston clinical convention.

(b) *Alternate Delegate to AMA.* To serve Dr. Hill's unexpired term as Alternate Delegate to AMA, President Brumby appointed Dr. C. D. Taylor, Jr., of Pass Christian, who was Delegate-elect. On Jan. 1, 1971, Dr. Taylor entered his regularly elected term as Delegate, and Dr. Hill entered his regularly elected term as Alternate Delegate.

(c) *CHP Manpower Study.* The Division of Comprehensive Health Planning, Office of the Governor, has initiated a health manpower study. To represent the association on the study task force, President Brumby appointed Dr. Warren N. Bell of Jackson, who ably represented us in a similar study made in 1969 by the Mississippi Hospital Association.

(d) *Nomination to AMA Council.* President Brumby nominated Dr. William E. Lotterhos of Jackson for reappointment to the AMA Council on Scientific Assembly, and in December 1970, the AMA Board of Trustees made the reappointment.

Organization of the Board. One new Trustee, Dr. Lyne S. Gamble of Greenville, District 1, was welcomed to the Board during 1970-71, bringing to a total of seven new Trustees since 1967.

Officers of the Board during the year are Drs. Mal S. Riddell, Jr., of Winona, chairman; J. T. Davis of Corinth, vice chairman; and William O. Barnett of Jackson, secretary.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

In its annual report to the House of Delegates, the Board of Trustees has furnished information on matters relating to routine management of the association's affairs and on referrals to it by the House of Delegates at the 1970 annual session. A reading of the report demonstrates the massive tasks and demands for time and service which are placed upon our Board of Trustees. We approve the report, express our appreciation to the Board and general officers for their continued exercise of leadership and recommend adoption of the report.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT A OF THE BOARD OF TRUSTEES

Petition for Transfer. Union County is within the geographic and professional jurisdiction of the North Mississippi Medical Society, and under the provisions of Section 8, Chapter VIII, By-Laws of the association, it is assigned to District 2. The six physicians of Union County, all members of the association in good standing, have petitioned the Board of Trustees to reassign the county to the Northeast Mississippi Medical Society.

The request is made because of the proximity of the petitioners to the Tupelo area and because of practice patterns and convenience in participating in component medical society meetings. The petition is unanimous and in good order.

To accommodate the request, it is necessary to amend the charters of the North Mississippi and Northeast Mississippi medical societies to reflect the transfer of this county between the profes-

sional jurisdictions. The Board approves the request and recommends approval by the House of Delegates.

Amendment to the By-Laws. The North Mississippi Medical Society is in District 2, while the Northeast Mississippi Medical Society is in District 3. To avoid having a split Trustee district, it is necessary to amend the By-Laws defining these districts.

Accordingly, the Board recommends that so much of Section 8, Chapter VII, By-Laws of the association as reads "District 2: . . . Union . . . " be deleted and amended to read "District 3: . . . Union. . . ."

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

A proper petition has been filed with the Board of Trustees by the six physicians in Union County requesting transfer of their professional society jurisdiction to the Northeast Mississippi Medical Society from the North Mississippi Medical Society. The Board has approved this request and recommended that the House of Delegates also give approval. Your reference committee concurs and recommends that charters of the two societies involved be amended to facilitate this transfer.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

To facilitate the transfer of Union County to the Northeast Mississippi Medical Society from the North Mississippi Medical Society and to avoid having a split Trustee district, it is necessary to amend the By-Laws with reference to definition of Districts 2 and 3.

Accordingly, your council recommends that so much of Section 8, Chapter VIII, By-Laws of the association as reads "District 2: . . . Union . . ." be deleted and amended to read "District 3: . . . Union. . . ."

The report of the council, acting as a reference committee, was adopted.

SUPPLEMENTAL REPORT B OF THE BOARD OF TRUSTEES

Medical Care Foundations. Medical care foundations are the most widely discussed, universally considered innovations in private health care delivery in the United States today. They are creatures and devices of medical organization, operated under medical sponsorship and control. Because of their unique structure and purpose, MCF's are today a widely accepted private care delivery vehicle to the profession, public, care financing mechanisms, and government.

The proliferation of care foundations has been encouraging and exciting. There are 16 MCF's in California serving 1.5 million patients and 6,000 physicians. In the south, foundations have been established by the state medical associations in Georgia and Florida.

State associations are sponsoring MCF's in Arizona, Colorado, Illinois, Iowa, Hawaii, Minnesota, New Mexico, New York, and Pennsylvania. About 25 other state associations are in planning and developmental stages, preparing for foundation sponsorship. Ongoing MCF's are overseeing care delivery under voluntary prepayment, private voluntary health insurance, Medicare, Medicaid, and CHAMPUS.

Under medical sponsorship, existing MCF's have organized nationally into the United Foundations for Medical Care, and representatives of our association attended and participated in one of four regional meetings of UFMC recently at Charleston, S. C. Our president represented us at the 1971 AMA Congress on the Socioeconomics of Health Care at Las Vegas where the care foundation was the principal subject for study and discussion.

MCF Functions. Generally, care foundations have four principal functions:

(1) To conduct peer review, generally considered the heart of the foundation concept in which physicians oversee medicine's house.

(2) To provide for the medical profession's assuming direct responsibility for and leadership in care delivery.

(3) To provide the most knowledgeable and capable source for claims processing and payment, a function integral to the review and responsibility concepts and functions.

(4) To sponsor utilization review, assuring that expensive and sometimes scarce facilities are optimally employed at maximum possible efficiency.

MCF Purposes. State association care foundation corporate charters include five purposes common to MCF's:

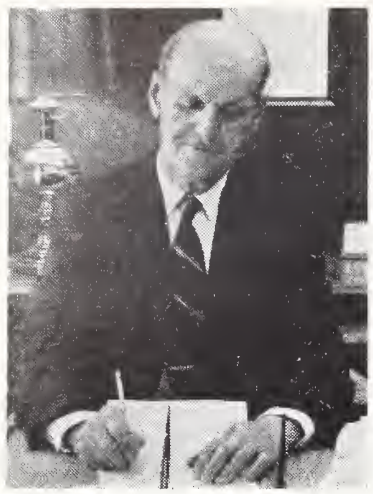
(1) To promote, develop, and encourage the distribution of medical services in the area served at a cost which is just and equitable to patient and physician.

(2) To preserve freedom of choice.

(3) To guard, preserve, and foster the physician-patient relationship in the traditional, time-honored sense.

(4) To protect the public health.

(Turn to page 440)



The President Speaking

'The Facts Prove Differently'

ARTHUR E. BROWN, M.D.
Columbus, Mississippi

DAY BY DAY the propaganda machines are grinding out their copy pointing out the failure of the medical profession to provide programs designed to improve the delivery of health care. They point in particular to the acute shortage of physicians.

There is another side of this story that has not appeared in the liberal press. The complex nature of medical and health needs makes it difficult to determine exactly how many physicians are needed. The American Medical Association has even been accused of limiting the number of medical schools it approves and of limiting the enrollment in the schools that it does approve.

The facts are that since June 1951 the AMA has operated under a policy adopted by its House of Delegates entitled "Policy of the American Medical Association Regarding the Production of Physicians." Under the impetus of this program national goals were identified and a ratio of physician-to-population was established. In 1959 physician total showed a ratio of 149 physicians to 100,000 population. In December 1970 it was 165 per 100,000 people. On the present projected output of physicians it is estimated there will be 180 per 100,000 by 1975.

This program called for the establishment of 20 to 24 new schools by 1975. The goals that were set have been achieved, exceeded or appear to be well within reach before the 1975 deadline. In 1959 there were 85 medical schools, 75 four year schools, four two year schools and two in developmental stages. Today there are 103 medical schools—87 four year, six two year and 10 in development. In addition, five new schools are planning to accept students in the fall of 1971 and another five schools are to open in 1972.

Former President Johnson in 1967 estimated the physician shortage to be 50,000. This figure is still being quoted even though the year 1968 showed a net gain of 8,406 physicians. There was a net increase of 7,906 in 1969 and 9,086 in 1970. This adds up to a total of over 25,000 in three years and yet we are still being accused of doing nothing.

These figures made interesting reading and some interesting conclusions may be drawn. The projection of needed physicians was made in the 1950's. These changes were initiated by our own medical organization before the onset of the vast socioeconomic upheaval of the 1960's. These changes were brought about by physicians because they accepted the responsibility of providing for the medical needs of our changing society. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 8
AUGUST 1971

EDITORIALS

The Craft of Medical Care Plan Fiscal Administration

I

MEDICAL CARE PLAN administration, the business of managing the government's business as a fiscal administrator or intermediary, has quietly grown into a major component of care financing. Although nobody knows for sure, it is reliably estimated that 60,000 Americans are employed full time in the administration of Medicaid, Medicare, and CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).

The Blue plans are biggest in the field, so much so, in fact, that their *raison d'ètre* appears to be fiscal administration of tax-supported medical care programs rather than their traditional role of prepaid care. A recent study by the Social Security Administration shows that in 37 states, the Blue Cross plans paid out more under government programs than for regular business. Some plans paid up to 500 per cent more in benefits as fiscal intermediaries than for Blue Cross.

While occupying second chair in this smoothly orchestrated symphony of shekels, the private insurance community is also where the action is. The 15 top companies don't put this in their respective annual reports, but 9 per cent of their operating income is derived from Medicare administration. And that's not the half of it: Great American Life receives 75.3 per cent of its administrative expense income from Parts A and B of Medicare, while Pan American receives 57.2 per cent. Nationwide, the company supporting enactment of Medicare, is on the SSA payroll for 71.3 per cent.

Altogether, there is one thing badly out of balance in this picture: There are simply not enough physicians actively engaged in fiscal management of government care programs which largely leaves medicine without a voice. The medical care foundation may be the remedy for this, because American medicine is finding out that he who adjudicates the claim and writes the check controls the program.

II

There is only one possible rationale for the government's hiring somebody to run a medical care plan. This is to assure that the job is done by an organization already in the business and hence assumed to possess savvy and know-how. The other aspect is that the fiscal administrator or intermediary can do the job more efficiently and for less cost than the government. The very fact that the Social Security Administration has undertaken such studies suggests that the subject may be one for debate.

Fiscal administration involves great responsibilities but little or no risks. The administrator assumes no underwriting functions, serves his

group of beneficiaries without actuarial exposure, and generally has to pay little attention to payout and such business-oriented problems of the industry as loss ratio, earned premium, and incurred loss. As one wag put it, the intermediary is a little like Christopher Columbus who started out not knowing where he was going. When he got there, he didn't know where he was, and when he got home, he didn't know where he'd been. And he made the entire trip on somebody else's money.

The quip is, of course, good humored ribbing, because most government care plan fiscal administration is efficient, even if they sometimes tend to be abrasive to providers, and this need not be the case. In Medicare, there has been a progressive tightening of the program as costs continue to mount. The word went out to the carriers who, in turn, tightened the screws on benefits. Physicians often observe that the reading of the book by the checkwriter is tougher than the regulations promulgated by the government.

From the side of the medical profession, it can rationally be argued that effective peer review with concomitant utilization controls can produce somewhat opposite and positive results, more often than not in the form of usual, customary, and reasonable fees and less red tape. An illustration is the CHAMPUS program directly administered by five state medical associations and by three other state medical associations in partnership with Blue Shield and insurance companies.

III

Apparently, the Veterans Administration pioneered the concept of the fiscal administrator acting for and in behalf of the government. In 1945, the VA made contracts with state medical associations which were, believe it or not, the first fiscal administrators. This was for the VA Home Town Care Program which permitted veterans, with prior authorization, to secure care from their private physicians.

Then came Vocational Rehabilitation, Crippled Children's, and Maternal and Child Care services under fiscal administration by private organizations in some states. When the Congress amended the four welfare or categorically indigent titles in 1950, a few states named fiscal administrators for the old pooled vendor medical programs for the aged, dependent children, blind, and disabled. Next was Kerr-Mills for the medically indigent aged and then Medicare and Medicaid.

CHAMPUS was born on Capitol Hill June 7, 1956, to become effective in six months. The Dec. 7, 1956, implementation date does not, as some like to believe, have anything to do with Pearl Harbor and health care benefits for our military. While not without its ups and downs, CHAMPUS must be considered a model program, and it is second only to Medicare in scope as a purely federally funded enterprise. CHAMPUS now covers almost 10 million active duty dependents and retired personnel, just about half the size of Medicare. Yet is operated with only a fraction of the fanfare and with notable and few exceptions, it has been brought under the concept of true usual, customary, and reasonable fees. The Mississippi State Medical Association takes pride in its stewardship of the program as it approaches its 15th anniversary as fiscal administrator for the Department of Defense. And most important of all, it has been with physician-sponsorship, mostly to the benefit of the patient.



"It's not that we doubt your word, Mrs. Fedderson, it's just that this is our first case involving a fall from the grammar school monkey bars."

IV

The SSA studies show that in 1968, Blue Cross paid $3.6 billion in hospital benefits under its regular business. That same year, it paid out $3.7 billion under Medicare, and the gap has since widened. Montana Blue Cross was the champ, paying out 507 per cent more under Part A than it did to its regular subscribers. Blue Cross plans paying out double to over-65 beneficiaries over contract holders were Florida, Washington, Arizona, New Jersey, Iowa, Nebraska, Minnesota, and Idaho.

In 1968, Blue Shield paid out $1.5 billion to physicians for subscribers and $1.2 billion as a government fiscal administrator, and here again, the gap has widened. These are indices as to the lively interest of the Blue plans in government program administration.

SSA said in the study report that "nationally, the administrative expense of Blue Cross plans under Medicare in 1968 amounted to 19 per cent of aggregate operating expense under regular business.

"For Blue Shield," the report continues, "the proportion was 48 per cent." But the Florida Blue Shield plan received 146 per cent Medicare administrative expense reimbursement to the ratio of regular business.

For more than a decade, the Mississippi State Medical Association had administered the CHAMPUS program for about 5 per cent of the aggregate payout. It is almost axiomatic that the less spent for administration, the more there is to spend on medical care. This also is the concept of the medical care foundation which is bursting out all over.

It can operate in a complementary manner with other programs, even to the extent of acting for a Blue plan, as is the case in California. But most important of all, the foundation places the physician squarely in the fiscal administration picture where he has full knowledge of how the plan is operated, where he exercises his voice in its management, and where he shares responsibility for making the enterprise work.

Physicians are recognizing that they cannot merely call attention to fiscal administration vexations, leaving the job of putting things right to somebody else. They realize—and are saying so with medical care foundations—that they must become part of the management team. The stakes are too high in terms of care delivery and the well-being of the patient for things to be otherwise.—R.B.K.

Sun Valley and the Shattered Icon

This has got to go down as the year of the shattered icon, if the recent Sun Valley Forum on National Health is any sort of indicator. Billed in advance as a staged affair for compulsory national health insurance, capitation plans, closed panels, and the assorted tortured logic of those who would change the face of medical care, the Sun Valley Forum turned out to be anything but.

Dr. Victor R. Fuchs of the National Bureau of Economic Research and something of a critic of medical care costs offered the biggest surprise when he questioned whether there is really a shortage of physicians in the United States. He said that his studies indicate excess capacity among physicians, especially those who do surgery. He blamed maldistribution of physicians, both geographically and by specialty, for the ills of the care delivery system.

Then Dr. Fuchs dropped a bomb by stating that "the poor in this country probably have more access relatively to medical care than they have to most other goods and services. It is the terms and the conditions under which they receive such care that cause much of the discontent."

The Forum's most notable conclusion was that "a very large number of Americans are over-doctored, over-hospitalized, and over-drugged." The finding challenged the popular notion that the way to improve the nation's health is by pouring out more tax dollars with an endless increase in the amount of medical services.

The Forum concluded that the pressing need is better allocation and more intelligent use of existing medical care resources. Moreover, it said, Americans need to learn how to take care of themselves.

Now, that could not have been put any better by the association's Committee on Peer Review.

The Forum blasted the public for dietary habits and digging its grave with its teeth. Also under the gun of resolutions were lack of exercise, cigarette smoking, excessive consumption of alcohol and other drugs, and general inattention to healthy living.

The Forum said that the nation would benefit a great deal more in paying a little attention to health habits than it would from having more physicians and more hospital beds "to treat them after their habits had laid them low."

Dr. Charles L. Shultze of the Brookings Institution, a conservative research organization, said that it is wrong to try to thrust the whole

cost of the nation's medical care upon the shoulders of the taxpayers. He pointed out that 70 per cent of all U. S. citizens are able to pay for medical care with no outside help except, perhaps, for catastrophic illness.

Dr. Shultze found another nerve and pressed hard: Why, he asked, should the tax structure pay all medical care costs when there are certain very high priority tasks which can only be paid for out of public funds? He argued for purchase of medical care through the private sector, stating that it is foolish to load it onto the already-overburdened federal budget.

The conferees singled out Medicare and Medicaid for special criticism as providing a boon economically to hospitals with little or no incentive for containing costs. Again, the Committee on Peer Review couldn't have said it better.

The liberal *New York Times* was moved to say that "at a time when congressmen are starting to try to outbid each other on massive new programs for national health care, the Sun Valley Forum has raised some cautionary flags about the kind of programs that are really needed and can do the most good."

If that sounds incredible, then listen to what the *Times* added: "The nation doesn't yet know why the existing huge outlays on medical care do not produce better results. And it could use more evidence—from sizable experiments in new medical delivery systems—before rushing into a radical restructuring of the entire medical system."

Billed in advance as a bust for the private sector, the Sun Valley Forum may have been the most significant convocation on medical socioeconomics of 1971.—R.B.K.

Store-Front Methadone: Wise or Foolish?

There is disagreement among respected authorities as to the value of the methadone regimen for narcotic addicts. Now comes an example of how the program can be misused, illuminating the dangers implicit in any methadone program with less than total medical management.

The Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs cancelled the permit of a New York physician conducting a methadone program for heroin addicts in his store-front clinic. He was operating under a Public Health grant, supposedly caring for 3,800 addicts in New York City. Site visits disclosed that there was little or no screening in the program, that medical management was minimal to nonexistent, and that the drug was indiscriminately dispensed. In fact, a good many were receiving it who may not have been heroin addicts at all. BNDD says that there is the possibility that some of the methadone was diverted into illicit channels.

All of this should serve as a stern warning, reminding us that fighting fire with fire is tricky business. Obviously, the purpose of these observations is not to get into the merits or demerits, whatever they may be, on methadone withdrawal. That's a question for the experts. This is to say that such programs ought to be institutionalized under the tightest medical management and security and that the closest scrutiny simply must be maintained.

It avails the patient little to permit such goings on in the name of medical care when the very purpose of the program is totally perverted, even possibly making new addicts instead of withdrawing those addicted to narcotics. In short, what belongs in the major medical center shouldn't be allowed in the store-front clinic.—R.B.K.

Pollution and Environmental Sloganeering

The Chamber of Commerce of the United States, a resourceful and enlightened organization more representative than any other of the nation's economic community, has some unique thoughts on pollution. The Chamber feels that the whole thing has been overdone.



"We thought we'd try a little different form of shock treatment."

None doubts that air, water, and land mass pollution is anything less than deadly serious, but the Chamber raises a logical point when it states that "alarming headlines about our nation's environmental problems appear to say that these are not questions at all but rather warnings based upon reliable evidence."

And the Chamber is essentially correct when it points out that the mass news media, with a responsibility for objectiveness, wander into "environmental sloganeering" and sometimes overlook the facts. Consider these points:

—*DDT is an environmental disaster:* With the use of DDT, Ceylon almost eradicated malaria, decreasing incidence of the disease to 110 cases in 1961 from 2.8 million in 1946. Then Ceylon was pressured into banning the insecticide, and there were 2.5 million cases of malaria in 1969.

—*FDA warns of mercury levels in tuna and swordfish:* The oceanographers tell us that mercury levels in the oceans have been unchanged for 90 years, and this also applies to fish which are caught and frozen.

—*Ban phosphate detergents:* Worse than the bubbles, one phosphate-free detergent, initially hailed as a nonpollutant, was ordered off the market by FDA when it was discovered that it contained alkali as a substitute, a worse pollution source than the phosphates.

—*Outlaw nonreturnable bottles:* The city of Bowie, Md., adopted an ordinance banning sale of soft drinks in nonreturnable bottles. Astonishingly, the *returnable* bottles were a greater source of solid waste litter than the disposables which folks tend to put into the garbage, whereas they like to think about getting their 2 cents back on returnables which lie around. The ordinance was repealed.

—*Lake Erie is dead:* Not to the commercial fishermen, it isn't. In 1970, the "dead" Lake Erie produced 50 million pounds of marketable and edible fish, half of the catch in all five of the Great Lakes. This is about the same quantity of fish taken from it in 1878, the first year of recording the catch.

Now, it should be readily recognized that these are examples and not absolutes. But to the extent that the exception does not necessarily prove the rule, the Chamber's assertion that we have gotten into sloganeering over environmental pollution has great credibility.

Of course there are grave and substantial pollution problems, what with raw effluent being dumped into rivers, industrial wastes which destroy wildlife, diesel fumes choking the driver in the morning traffic, and solid waste all around us. The pollution problem did not suddenly materialize. Rather, it is a cumulative process which now approaches serious dimensions in given areas. Just about everybody who thinks of it seriously recognizes that it will not be solved overnight.

In the meanwhile, it seems logical to maintain a reasoned perspective about pollution and avoid the "cause" approach with slogans, placards, picket lines, and the attendant hullaballoo. Problems are the price of progress, and progress with sufficient impetus usually solves problems. —R.B.K.

The Patient and Hospital Accreditation

The new standards of the Joint Commission on Accreditation of Hospitals which became effective last month have a twist not previously incorporated into them: The patient now has a say-so. Not that consumers can or should influence accreditation of a hospital, but their hitherto undefined status is now recognized clearly.

JCAH has promulgated what it calls the "patient's bill of rights," part of which is well-established in law. For example, the patient has a right to physical privacy in the hospital, and he has a right not to be used for teaching or research purposes except with his consent.

The standards also stipulate, as has medicine since Hippocrates, that no patient should be refused care because of race, creed, color, or source of payment of his bill. The commission says it will listen to patients, but it notes that "we've found that information consumers provide often isn't pertinent to the standards."

Almost no patient likes hospital food, schedules, and the enforced discipline necessary to assure optimal benefits of care. Most complaints from patients of poor treatment are rooted in the fact that a sick person isn't going to like much of anything short of regaining health. The Joint Commission also stresses that hospital accreditation does not and cannot guarantee the quality of medical care; it just guarantees that there is nothing about the hospital to prevent good care.

The new standards also make clear that the Joint Commission cannot cut off Medicare or Medicaid funds, except perhaps in the case of a tuberculosis or mental hospital. The gravest threat to a hospital refused accreditation is loss of AMA approval for training programs and loss of house staff. The commission foresees a slight decline in the number of accredited hospitals with the new and tougher standards, but the patient is in the picture as never before.—R.B.K.

PERSONALS

PANDELI ANAS of Jackson has joined the Jackson Surgical Group at 514-A E. Woodrow Wilson Drive for the practice of general, thoracic and vascular surgery. He is now associated with RUSH E. NETTERVILLE, GEORGE GILLESPIE, RAYMOND S. MARTIN, JR., and H. RICHARD JOHNSON.

THOMAS G. BARNES of Greenville was honored with a plaque in recognition of and appreciation for 15 years of service as team physician for Greenville High School at the annual Athletic Banquet.

GUY RAY BRASWELL, originally of McCool, has opened an office at 349 Highway 8 East in Grenada. Dr. Braswell limits his practice to ophthalmology.

JONATHAN C. CAMPBELL has associated with the Field Clinic of Centreville for the general practice of medicine and obstetrics.

J. P. CULPEPPER, JR., of Hattiesburg was presented the national "Distinguished Service Award" of the Arthritis Foundation "in grateful recognition of outstanding service and support in the fight against America's no. 1 crippling disease." Dr. Culpepper is currently vice president of the Mississippi chapter.

WILLIAM F. EASLEY, JR., a native of Hattiesburg, has joined the Rush Medical Group in Meridian for the practice of internal medicine.

CHARLES N. FLOYD, O. D. DABBS, JR., and H. K. ROSE, JR., all of Gulfport, have been appointed advisors to the Coast Counties Medical Assistants Association.

S. C. GALLOWAY has begun the practice of medicine at the Medical Clinic on First Street in Booneville. He is associated with PAUL C. ELLZEY, JOSEPH L. HURST, and W. CLEVELAND, JR.

KARL W. HATTEN of Vicksburg has been elected vice president of the Kidney Foundation of Mississippi for 1971-72.

G. SWINK HICKS of Natchez recently received a pin for 17 years of perfect attendance at the meetings of the Natchez Rotary Club.

D. L. HOLLIS of Biloxi has been named Outstanding Lion of the Year by the Biloxi Lions Club.

WENDALL B. HOLMES and W. T. MAYER of McComb held open house recently for their new building for rehabilitation of the blind and vocational rehabilitation on Marion Drive near Southwest General Hospital.

W. ROBERT HUDGINS announces the opening of his offices at Suite 303, Medical Towers, 440 E. Woodrow Wilson in Jackson for the practice of neurological surgery.

MORRIS ISAACSON, formerly of Grenada, has been appointed to the outpatient service in the Departments of Medicine and Surgery at the Jackson V.A. Center. Dr. Morris has closed his office at Adams and Pecan Streets in Grenada.

SAMUEL B. JOHNSON of JACKSON recently met with the Association of University Professors of Ophthalmology in Ponte Verde Beach, Fla.

BOBBY F. KING of Iuka has been elected president-elect of the Ole Miss Medical Alumni Chapter. A 1957 graduate of the University of Mississippi School of Medicine, Dr. King will assume the presidency at the May 1972 meeting of the alumni chapter.

GILBERT R. MASON of Biloxi and JOHN G. ATWOOD of Meridian have been named Diplomates of the American Board of Family Practice after passing the certification examination and meeting other requirements.

WILLIAM W. MAYERS of Laurel is serving as health chairman of the DeSoto District, Boy Scouts of America.

THOMAS J. MCDONALD and family of Mantachie were recently honored with an open house at the Mantachie Clinic. Dr. McDonald has begun a surgery residency at the University Medical Center in Jackson.

JAMES N. MCLEOD announces the opening of his offices at 838 Lakeland Drive in Jackson for the practice of internal medicine.

RICHARD C. MILLER of Jackson and UMC attended a surgical meeting at University Hospitals in Cleveland, Ohio.

CHARLES L. NEILL, JR., and LUCIEN R. HODGES of Jackson are accompanying Boy Scout Troop 18 of the First Presbyterian Church on a field trip to Colorado.

CARL G. NICHOLS, JR., of Leland and JAMES L. THORNTON of New Albany have been re-elected to active membership in the American Academy of General Practice.

Dale G. Read has associated with J. Manning Hudson, Robert E. Tyson, and David J. Vanlandingham in the practice of internal medicine at 514 E. East Woodrow Wilson Drive in Jackson. They have formed a corporation entitled Jackson Medical Associates P.A.

Leslie V. Rush, Sr., of Meridian has designed and manufactured a fracture operating table which is being used to surgically repair fractured bones with intramedullary pins. Dr. Rush's table allows positioning of the C-arm x-ray unit between the patient and the table.

James R. Russell, originally from Houston, announces his association with Harvey B. Wright of Laurel in the practice of ophthalmology at the Laurel Eye Center, 306 South 12th Avenue.

Richmond Sharbrough and Mrs. Sharbrough of Vicksburg are serving as co-presidents of the Vicksburg Swim Team.

Frederick E. Tatum of Hattiesburg was elected president-elect of the Mississippi Heart Association at the annual assembly in Jackson.

William E. Thornton announces the opening of his office for the practice of psychiatry at 1213 Broad Avenue in Gulfport at the Medical Arts Plaza. Dr. Thornton received his M.D. degree from Vanderbilt and completed his residency at Johns Hopkins.

Ralph Wicker has joined the Hattiesburg Clinic for the practice of neurosurgery. Dr. Wicker just completed his residency at the University of South Carolina Medical School.

Cecil T. Williams, Jr., has associated with the Medical Center at 535 N. 5th Avenue in Laurel for the practice of internal medicine and cardiology.

William L. Wood, Jr., of Tupelo received the Mississippi Heart Association's Bronze Distinguished Service Award at the annual assembly in Jackson. Dr. Wood also was elected secretary of the association.

NEW MEMBERS

Wakham, James Dale, Newton. Born Ruleville, Miss., March 2, 1941; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1965; interned Philadelphia General Hospital, Philadelphia, Penn., one year; elected June 1, 1971 by East Mississippi Medical Society.

DEATHS

Calhoun Archie Shepherd, Mt. Olive. M.D., Tulane University School of Medicine, New Orleans, La., 1911; member of the Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; died June 3, 1971, age 87.

Hand, Albert Powe, Shubuta. M.D., Tulane University School of Medicine, New Orleans, La., 1909; interned charity hospital, New Orleans, La., one year; member of the Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; died June 22, 1971, age 84.

Mitchell, C. B., Sr., Starkville. M.D., Tulane University School of Medicine, New Orleans, La., 1915; interned Vicksburg Charity Hospital, Vicksburg, Miss., two years; died June 2, 1971, age 78.

Smith, Charles W., Hattiesburg. M.D., Meharry Medical College School of Medicine, Nashville, Tenn., 1923; interned Flint Goodridge Hospital, New Orleans, La., one year; died June 20, 1971, age 78.

Watkins, Horace Clements, Jr., Quitman. M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1936; interned Roper Hospital, Charleston, South Carolina, one year; residency, same, July 1937 to July 1939; died May 26, 1971, age 58.

College of Physicians Takes Six State M.D.'s

Six Mississippi physicians specializing in internal medicine have been initiated into the American College of Physicians.

Granted fellowship are Dr. John M. Pearson of Hattiesburg, Drs. Alvin E. Brent, Jr., Bernard J. Dreiling, Theodore D. Lampton, and William M. McKell, Jr., of Jackson, and Dr. Findlay G. Maier of Pascagoula.

The new Fellows have earned this distinction through certification by their specialty boards, presentation of published material and evidence of scientific accomplishments and academic or hospital affiliations.

Dedicated to upgrading medical care, teaching and research through stringent standards of membership and programs of continuing education, the 56-year old College now has granted fellowship to 17,000 physicians.

AMA President Sees Staff on Visit

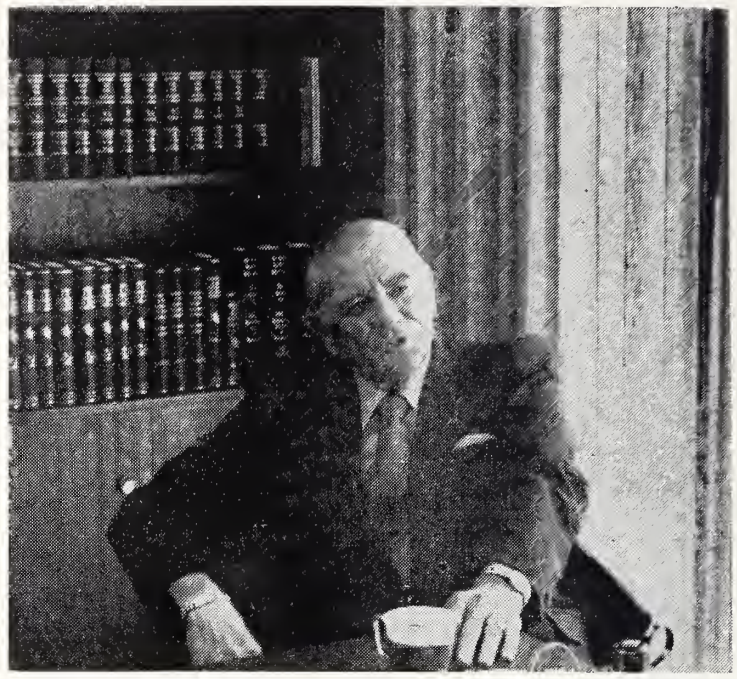
AMA President Wesley W. Hall of Reno, Nev., likes to know what makes it work.

In a surprise visit to the headquarters building of the Mississippi State Medical Association at Jackson, he devoted a day to visiting staff divisions, asking about programs, and inquiring into almost every aspect of association administration and services.

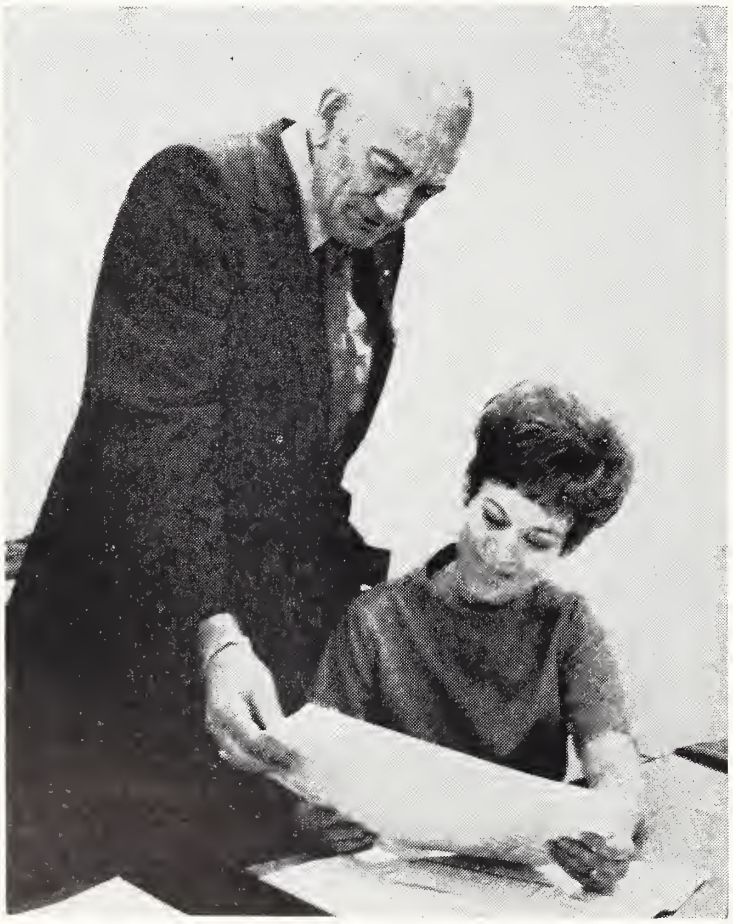
"I helped open and organize the first office of the Nevada State Medical Association," he told the staff members, "and I have never lost my enthusiasm for making certain that every level of medicine has skilled staff support.

"Our boards, councils, and committees require services from the executive staff in research, studies, information gathering, and preparation of materials," Dr. Hall said.

During his visit, Dr. Hall conferred with staff executives, showed a lively interest in membership and biographical data records, the new central billing system, JOURNAL production, annual session planning, Board and committee support services, CHAMPUS administration ("how do you handle so much paper?"), and data processing.



Over a cup of coffee, Dr. Hall explains how he helped organize the first central office for the Nevada State Medical Association.



Dr. Wesley W. Hall, AMA president, expresses interest in computerized membership reports to component societies, as shown by Barbara Shelton, director of administrative services at MSMA headquarters.

While a member of the AMA Board of Trustees of which he was chairman, Dr. Hall said that he was always interested in the Chicago headquarters operations and in staff work. He was instrumental in bringing about many recent reorganization and modernization changes in AMA.

Dr. Hall, a native Mississippian, said that he intends "to find my way home as often as I can while I am president of AMA." He has two scheduled speaking engagements in Mississippi in 1971, he added.

He was inaugurated 126th president of the American Medical Association at the June Atlantic City annual convention. He will address the clinical convention slated for New Orleans Nov. 28-Dec. 1, this year.

Dermatologists Plan Scientific Meeting

The American Academy of Dermatology (AAD) will hold its 30th Annual Meeting at the Palmer House, Chicago, Ill., Dec. 4-9, 1971.

The Academy, whose 3,500 members constitute most of the practicing dermatologists in the United States and Canada, plans to have two days of in-depth postgraduate courses on Saturday and Sunday, Dec. 4-5, followed by four days of general scientific sessions.

Book Review

Medical Parasitology. By J. Walter Beck, Ph.D., and Elizabeth Barrett-Connor, M.D. 210 pages with 150 illustrations. St. Louis: The C. V. Mosby Company, 1971. $10.75.

This volume presents in a concise manner a survey of the parasitic diseases of man. The arrangement is that of a series of lectures for undergraduate students: orderly, brief, authoritative. A group of review questions is appended to each chapter. A very few, select references are provided.

The lectures are rounded out with appendices providing proper laboratory techniques for demonstration of the various organisms.

Each parasite is dealt with from the standpoints of general classification, epidemiology, life cycle, morphology, epidemiology, pathology, symptomatology, diagnosis, and treatment. A large number of tables, diagrams, and drawings embellish and add clarity to the text. The photographic reproductions are very poor. Many are of such inferior quality that they should never have been permitted.

The emphasis is on the laboratory side; the clinical topics are relatively sketchy. Principles of therapy tend to be didactic.

The authors' stated purpose is to furnish a study guide for the student and a refresher course for the physician, without attempting to supplant standard reference texts or the most recent therapeutic guides. This objective is fully realized. The volume is recommended within these limitations.

E. L. Posey, Jr., M.D.

New Books Received

Obstetrics and Gynecology. By J. Robert Wilson, M.D., Clayton T. Beecham, M.D., and Elsie R. Carrington, M.D. 4th Edition. 638 pages with 525 illustrations. St. Louis: The C. V. Mosby Company, 1971. $19.80.

Medical Parasitology. By J. Walter Beck, Ph.D., and Elizabeth Barrett-Connor, M.D. 210 pages with 150 illustrations. St. Louis: The C. V. Mosby Company, 1971. $10.75.

Guides to the Evaluation of Permanent Impairment. Edited by the AMA Committee on Rating of Mental and Physical Impairment. 164 pages with illustrations. Chicago: AMA, 1971. $5.00.

The Secretory Immunologic System. Edited by Parker A. Small, Jr., M.D., D. H. Dayton, Jr., M.D., R. M. Chanock, M.D., H. E. Kaufman, M.D., and T. B. Tomasi, Jr., M.D., Ph.D. 544 pages with 111 illustrations. Washington, D. C.: U. S. Government Printing Office, 1971. $5.25.

Speech Pathology. By William H. Perkins, Ph.D. 449 pages with illustrations. St. Louis: The C. V. Mosby Company, 1971. $11.75.

MTRDA Helps Buy X-Ray Films

Over $10,000 has been given to the State Board of Health by the Mississippi Tuberculosis and Respiratory Disease Association for the purchase of x-ray films for county health departments throughout the state.

The association president, Mrs. R. S. McLaurin, of Brandon, said the gift was from the 1970 Christmas Seal funds, which are used in various ways to fight tuberculosis and other respiratory diseases.

"Through the years this state voluntary health organization and its active county components," said State Health Officer Hugh B. Cottrell, "have been a strong ally of public health in our efforts to control tuberculosis."

Dr. Cottrell said the association's check for $10,238.80 would buy approximately one-fourth of the x-ray films used this year in the state's tuberculosis control program.

Commenting on the importance of x-rays in the program, Dr. Durward Blakey, director of Preventable Disease Control for the State Board of Health, said:

"The x-ray is still the basis on which we manage all our tuberculosis cases, and it is the basis on which we evaluate contacts and suspects for evidence of disease.

"Consequently, it is the single most important laboratory and diagnostic tool at our command in the continuing practice to control and suppress tuberculosis."

Last year, he said, 103,849 x-rays were made by the county health departments and the State Board of Health mobile units.

Dr. Burman Is Named Physician of the Year

Dr. Richard G. Burman of Gulfport was named the "Outstanding Physician of the Year" by the Mississippi Society of the American Association of Medical Assistants at their state convention in Tupelo.

Dr. Burman, who is currently serving as one of 10 national physician advisers to the AAMA, limits his practice to obstetrics and gynecology.

He received his M.D. degree from the University of Louisville Medical School and completed ob-gyn residency training at Tulane and the Ochsner Foundation Hospital.

Dr. Burman is a member of AMA, MSMA, Coast Counties Medical Society, American College of Obstetricians and Gynecologists, Southern Medical Association and Southern Obstetrical and Gynecological Society.

He has been a professional delegate for Mississippi to the House of Delegates of the American Cancer Society, 1966-1971, a member of the Mississippi Interagency Advisory Commission on Heart, Cancer and Stroke and a Mississippi representative to the Committee on Relative Value Scale of ACOG.

Toy Toilet Articles Recalled

The Mississippi State Board of Health has received notification from the Food and Drug Administration that toy toilet articles, with the trade name "Merry Lather N' Lotion Toy Toiletries," have been found to be contaminated with a dangerous bacteria.

The bacteria—Pseudomonas aeruginosa—is especially dangerous to the eyes if a sore or abrasion is present. The germ can also cause infections of the ear, nose and throat, as well as the skin, and presents a severe health hazard to children.

Dr. W. E. Riecken, Jr., head of the accident prevention program of the State Board of Health, reports that the manufacturer is voluntarily recalling this potentially dangerous item from retail distribution, but more than 18,000 kits have been distributed since the first of March of this year.

"While no deaths or injuries have been reported from the product so far, parents who have purchased it are advised to remove the item from their child's playthings," said Dr. Riecken.

The product is sold in a six by nine inch blue display card containing "shaving cream," "shaving lotion" and a toy razor. It is labeled "Merry Lather N' Lotion Toy Toiletries" and is made by the Merry Making Manufacturing Company, a subsidiary of Leisure Dynamics, Inc. of Cincinnati, Ohio. The retail price of the kit is $.49.

CHAMPUS Deductible Procedures Clarified

CHAMPUS officials have clarified the deductible charge payable under the outpatient portion of the Civilian Health and Medical Program of the Uniformed Services.

The CHAMPUS deductible, similar to deductibles in auto, health and other insurance, is an initial amount the individual is responsible for without assistance from the cost-sharing provisions.

Under CHAMPUS the deductible has to be met each fiscal year (July 1-June 30). The amount is $50 when only one authorized beneficiary uses the program and $100 if two or more members of the family are receiving civilian health care under CHAMPUS.

As soon as these charges are incurred, the beneficiary completes his portion of the claim form, then sends the form with his itemized bills or receipts to the state fiscal administrator, MSMA in Mississippi, who issues the deductible certificate.

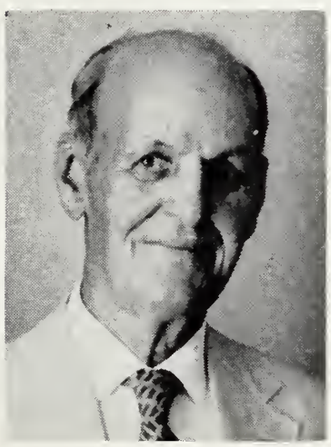
Physicians' or dentists' bills or receipts must show the patient's name, diagnosis or nature of illness or injury, the care or service provided, the date and the charges. Drug bills or receipts must show the name of the pharmacy, patient's name, prescription number, date filled and the charges. In the case of insulin, no prescription number is required but the bill must show "insulin."

Outpatient expenses incurred in states and countries other than where the beneficiary resides may also be used to satisfy the deductible. All charges to satisfy the deductible should be sent to the fiscal administrator in the state of residence.

After the deductible has been met, out of state charges up to $25 may still be sent to the state of residence fiscal administrator, but charges exceeding $25 must be sent to the fiscal administrator in the state where the charges were incurred with a copy of the deductible certificate.

Association Gets Grant Award for Model Quality Care Review Program

The Mississippi State Medical Association has been awarded a research grant of $369,619 for development of a model physician-sponsored peer review program. The award was made by the National Center for Health Services Research and Development of the U. S. Public Health Service. Term of the grant is two years.



Dr. Brown



Dr. Davis

This was the announcement simultaneously made by the National Center from Washington and Drs. Arthur E. Brown of Columbus, president of the association; J. T. Davis of Corinth, chairman of the Board of Trustees; and Millard S. Costilow of North Carrollton, chairman of the Committee on Peer Review.

"We are gratified and challenged by the award," the association officials said, "and we feel that it will accelerate by at least three years the progress in health care delivery which can be attained by the Mississippi Foundation for Medical Care."

The foundation, authorized by the House of Delegates at the 103rd Annual Session, has been incorporated and will be organized this month when directors and physician-officials of the board are elected. The House of Delegates also directed that peer review and quality care delivery programs be brought under the foundation.

Funding for the first 11 months through May 31, 1972, is $173,890, Dr. Costilow said. He acted as the Board's representative at Washington in June, appearing before a panel of non-federal physicians and experts on behalf of the Mississippi program. From among an estimated 50 applicants, two state medical associations, Hawaii and Mississippi, and two large county medical societies, Sacramento, Calif., and Albermarle County, Va., received awards.



Dr. Costilow

"The program will be that approved by the House of Delegates in May," Drs. Brown, Davis, and Costilow said.

"There are no federal guidelines or requirements, and the project will be that of the association. Our only obligation as investigators is to publish our findings and evaluation of the quality care review system," they added.

Speaking for the Board of Trustees, Dr. Davis said that staff at association headquarters will be augmented to support the massive tasks of physician-sponsored review. He said that on a large scale, the association "will be doing just about what it has been doing with CHAMPUS for 14 years." Dr. Brown said that the general officers and Board are proceeding with the Mississippi Foundation for Medical Care, having conducted a special meeting since the annual session to map out organizational structure and ini-

tial policies within the framework of authorizations approved by the House of Delegates.

The president said that the foundation will be organized, the directors and physician leaders named, and executives designated this month.

Dr. Costilow said that the program will be physician-oriented, making use of review physicians on a rotating basis with still other physicians designated as district utilization review consultants.

The program will review cases from third party sources, public and private, and draw specialized and detailed information from hospitals, Dr. Costilow added.

"There will be an educational product of the program," the peer review chairman emphasized. "It is aimed at being educational and will be nonpunitive. Data arrays will be furnished periodically to hospital staffs showing care rendered in a given period and comparing quality indicators for that staff with the state at large.

"The entire thrust of the program," Dr. Costilow continued, "is improvement in care quality, enhanced assessibility to care, validation of medical necessity, and continuing study of costs."

The program is officially called an Experimental Medical Care Review Organization or EMCRO for short, the officials said. During the project, the association will periodically publish findings and evaluations as it develops the program.

The project will be conducted under association-developed policy with physician-sponsorship and management. Data will be computer-processed, Dr. Costilow said, with physician review at every level.

Additional staff will include a director and review technicians, the latter being trained much in the same manner as CHAMPUS claims adjudicators. They will work on a day-to-day basis with review physicians and the Committee on Peer Review.

The program will be brought under the new foundation, which is also sponsored and operated by the state medical association. The grant will enable the program to tool up, staff, and equip, Drs. Brown, Davis, and Costilow said.

"Eventually, the operating expense for the review project will come from modest charges per case by the foundation, as set out in the House of Delegates' policies," they said.

The foundation will also have the capability of administering medical care plans and paying claims, exactly as the association has administered the CHAMPUS program for 14 years. This program includes physician-conducted review, but the new program will probe deeper into care quality, the officials added.

The new program and foundation will be housed in the association's Jackson headquarters building.

Medical Assistants Hold Convention

"Mission Impossible" was the theme for the 5th annual convention of the Mississippi Society of the American Association of Medical Assistants recently held in Tupelo at the Sheraton Motor Inn. Mrs. Dreatha Carter, president, Greenwood, presided; Mrs. Colleen Waycaster, Tupelo, served as convention chairman.

The "Mini Test," a simulated certified medical assistant examination, under the supervision of Mrs. Mary Adeline Pace, CMA, AAMA trustee, and a workshop entitled "Physec" presented by Dr. Robert L. McKinley, Tupelo, were program highlights.

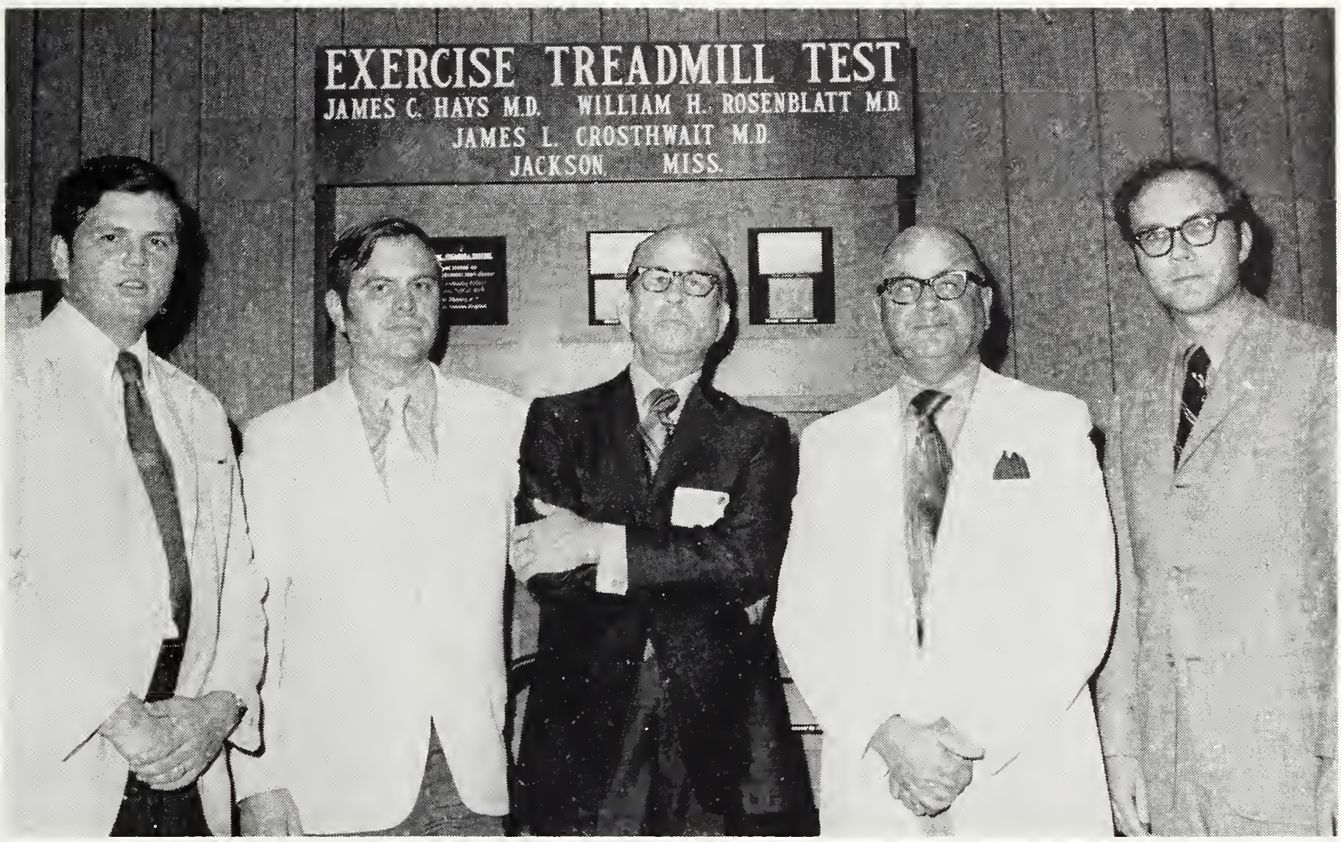
Mrs. Jean A. Borger, communications division, National Association of Blue Shield Plans, Chicago, was luncheon speaker and also moderated a panel discussion, "Kaleidoscopic Views of a Medical Assistant." Panel participants were E. L. King, administrator, North Mississippi Medical Center, Tupelo; Dr. A. Eugene Lee, adjunct professor of law, University of Mississippi, Oxford; W. C. Mosley, vice-president, Mississippi Hospital and Medical Service, Jackson; and Mrs. Pace, administrative assistant, University of Mississippi Medical Center, Jackson.

Serving as master of ceremonies at the banquet was C. T. Walker, director, hospital and professional relations, Mississippi Hospital and Medical Service, Jackson. Dr. Lee also served as the speaker for the evening, reminding the attendants of a medical assistant's legal responsibilities to her employer and his patients.

The annual award of "Physician of the Year" was presented to Dr. Richard G. Burman, Gulfport, who has served the organization as local, state, and national advisor.

Newly elected officers installed at the banquet by Mrs. Pace, installing officer, were president, Mrs. Thelma Van Cloostere, Gulfport; president-elect, Mrs. Marian Cook, Tupelo; vice-president, Mrs. Mary Brooks, Jackson; secretary, Mrs. Evelyn Wright, Tupelo; treasurer, Mrs. Elizabeth Hampton, Jackson; members of the board, Mrs. Colleen Waycaster, Tupelo, and Mrs. Mary Majure, Meridian.

Physicians Participate in MHA Annual Assembly



Attending the Mississippi Heart Association Annual Assembly in Jackson were Drs. James C. Hays of Jackson, Karl Hatten and Lucian M. Ferris of Vicksburg, William H. Rosenblatt and James L. Crosthwait of Jackson. Dr. Rosenblatt, serving on the Mississippi Heart Association Coronary Care Committee, is chairman of a 1972 training course for physicians in intensive coronary care. Dr. Hays is chairing the Heart Association segment of the Mississippi Health Exposition with Dr. Crosthwait assisting. Dr. Ferris is a past president of Mississippi Heart Association and both he and Dr. Hatten are currently serving on the Board of Directors.

Health Expo I Planning Gets Underway

More than 30 health-related and other organizations are planning exhibits, movies and demonstrations for Mississippi Health Expo I set for Oct. 1-3, 1971, at the Mississippi State Coliseum in Jackson.

Co-sponsored by the state medical association in conjunction with other groups, the health fair is designed for health education, recruitment into health careers and provision of health services including disease detection screening and referral.

Events are aimed toward the general public and include exhibits, screening and diagnostic testing, lectures, teaching sessions, information booths, movies and special teenage programs. There will be no admission charge.

Dr. C. G. Sutherland of Jackson is chairman of the MSMA Expo I committee. Working with him are Drs. Raymond S. Martin, Jr., Jim G. Hendrick, and Raymond F. Grenfell, all of Jackson. A member of the association has been appointed to work on every committee of the Expo.

Among the major organizations contributing or participating are: the American Cancer Society, American Red Cross, Medicare, Medicaid, Mississippi Academy of General Practice, Mississippi Dental Association, Mississippi Heart Association, Mississippi Hospital Association, Mississippi Regional Medical Program, Mississippi State Board of Health.

Also the University Medical Center, Mississippi State Nurses Association, University of Mississippi School of Pharmacy, Educational television, Mississippi Safety Council, Mississippi Society of Internal Medicine, and Comprehensive Health Planning, Mississippi Dietetic Association, Mississippi Kidney Foundation and other health and service organizations as well as government agencies.


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Precautions: Should be used with caution in patients who have glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.
Adverse Reactions: Side effects reported to date have been predominantly related to rash (which requires discontinuation of medication) and headache and gastrointestinal distress, which are usually mild and transient with continuation of medication. In some cases severe persistent headaches may occur. In addition, the following adverse reactions to nitrates such as pentaerythritol tetranitrate have been reported in the literature: (a) Cutaneous vasodilatation with flushing. (b) Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. (c) An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur, even with the usual therapeutic doses. Alcohol may enhance this effect.
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Warning: Tablets containing phenobarbital may be habit forming. PERITRATE with Nitroglycerin—pentaerythritol tetranitrate 10 mg with nitroglycerin 0.3 mg, bottles of 50 tablets.

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PE-GP-11

Blue Plan Announces Personnel Changes

Mississippi Blue Cross-Blue Shield has made certain personnel changes in the Hospital and Professional Affairs division, according to W. C. Mosley, vice president.

Aaron J. Johnston is the new director of the division and the Medicare-Medicaid coordinator. Larry Lawrence has been promoted to director of Medicare-Medicaid programs.

C. T. Walker has been promoted to director, Hospital and Physicians Services, Blue Cross-Blue Shield Claims. C. H. Smith remains as manager of the Blue Cross-Blue Shield claims department but has additional responsibilities under the reorganization structure.

Mike Hathorn has been promoted to manager of Provider Reimbursement, Medicare-Medicaid programs, which includes hospitals, extended care facilities, nursing homes and home health agencies. Dick Manning is new assistant manager of this division. Clarence Bell has been moved to manager, Provider Relations, Medicare-Medicaid.

SBH Explains Gonorrhea Diagnosis

The State Board of Health has recommended certain criteria for the diagnosis of gonorrhea in males, according to Dr. Durward Blakey, Director, Division of Preventable Disease Control.

Microscopic demonstration of gram-negative, intracellular diplococci on smear of a urethral exudate constitutes sufficient basis for a diagnosis of gonorrhea, said Dr. Blakey.

When gram-negative diplococci cannot be identified on direct smear of a urethral exudate, a culture specimen should be obtained from the anterior urethra and inoculated into either gonorrhea transport media bottles or directly onto gonorrhea culture plates where this service is available.

Dr. Blakey added that when a test-of-cure or a test for incubating gonorrhea is needed, a culture specimen should be obtained from the anterior urethra and inoculated as in the previous study.

Not recommended are fluorescent antibody staining of direct smears of urethral exudates or fluorescent antibody staining of urethral exudates or the delayed fluorescent antibody procedure.

Dr. Moore Heads SBH Family Planning Division

Dr. Steven L. Moore, formerly director of Comprehensive Health Planning in the Governor's Office, has returned to the State Board of Health as director of the Family Planning Division, according to Dr. Hugh B. Cottrell, State Health Officer.

Dr. Cottrell said that Dr. Moore will develop a statewide plan to coordinate the various efforts of agencies and groups rendering family planning services, in order to achieve an effective and efficient delivery system without overlapping and gaps.

Dr. Moore began his public health work in 1958 as a local health officer and in 1965 was called to the central office as assistant director and then director of the Division of Local Health Services.

A native Mississippian, Dr. Moore graduated from Millsaps College and received the M.D. degree from the University of Mississippi School of Medicine. He went on to earn the Master of Public Health degree from Harvard University.

The preventive medicine specialist is a member of the Mississippi State Medical Association, AMA, Central Medical Society and the Mississippi Public Health Association.

Southern Establishes Med Technology Program

The University of Southern Mississippi at Hattiesburg has established a department of medical technology, the first in the nation to be established in a non-medical school.

Establishment of the new department has been approved by the Board of Schools of the American Society of Clinical Pathologists.

Dr. William G. Brundage, associate professor of microbiology, will serve as chairman, and Dr. Thomas F. Puckett, director of the Hattiesburg Pathology Laboratory, will serve as clinical director.

Affiliated hospitals will be Memorial Hospital at Gulfport, Methodist Hospital and the Pathology Laboratory at Hattiesburg, and Singing River Hospital in Pascagoula.

A four-year program of academic and clinical instruction will be offered leading to the B.S. degree in medical technology.

The first years will consist of a comprehensive program designed to provide both a general academic background and the necessary technical prerequisites needed in medical technology.

The senior year is designed to conform to the recommendations of the American Society of Clinical Pathologists in order that students will be qualified for examination and certification by the Registry of Medical Technologists. The fourth year of training will consist of two phases. Phase I is a six-month clinical session at one of the affiliated hospital laboratories.

The second phase provides the student with a supervised rotation system in one of the affiliated hospitals to establish confidence and competency in all aspects of medical technology.

Upon completion of the program, the student will be eligible to take the registry examination given by the ASCP for certification as a medical technologist.

Mathews Appointed Welfare Commissioner

Charles L. Mathews of Jackson, former associate executive secretary of the state medical association, has been appointed acting Commissioner of Public Welfare by Gov. John Bell Williams and the Board of Public Welfare.



Mr. Mathews

Mathews succeeds Arthur Winstead who recently resigned the post for personal business and health reasons.

The Mississippi native was deputy director of the Mississippi Medicaid Commission before this appointment. Prior to his service with the commission, he was a staff assistant in the state's Office of Comprehensive Health Planning.

The 38-year old Mathews has a B.A. degree in sociology from L.S.U. and also studied law and public administration at L.S.U. and Syracuse University.

Active in professional and civic affairs, he holds membership in the Mississippi Society of Association Executives, American Society of Association Executives, Public Relations Association of Mississippi, Jackson Junior Chamber of Commerce, and is a commissioner of the Magnolia Little League.

Dr. Blackwood Gets UMC Leathers Award



Donald Blackwood of Drew, second left, was named winner of the coveted Waller S. Leathers Award at the University of Mississippi Medical Center 15th annual Commencement in Jackson, June 6. Chancellor Porter L. Fortune, left, and Dr. Robert E. Blount, right, Medical Center director and medical school dean, congratulate Dr. Blackwood for the honor, which goes to the medical graduate with the highest four-year average. Mrs. Blackwood is at second right. Dr. Blackwood was among 78 graduates who got the M.D. degree, the largest graduating class in the medical school's history. Graduates totaled 127, including 26 for the B.S. degree in nursing, 14 for the Ph.D. and nine for the M.S.

Interstate Postgraduate Program Planned

The Interstate Postgraduate Medical Association will hold its 56th annual scientific assembly in conjunction with the Arthritis Foundation Nov. 15-19 in New Orleans.

All lectures will be held at Rivergate Auditorium. There will also be informal noon discussions, live television, a banquet at the Roosevelt Hotel with Dr. Beverley T. Mead of Omaha as speaker, and special planned events for the ladies.

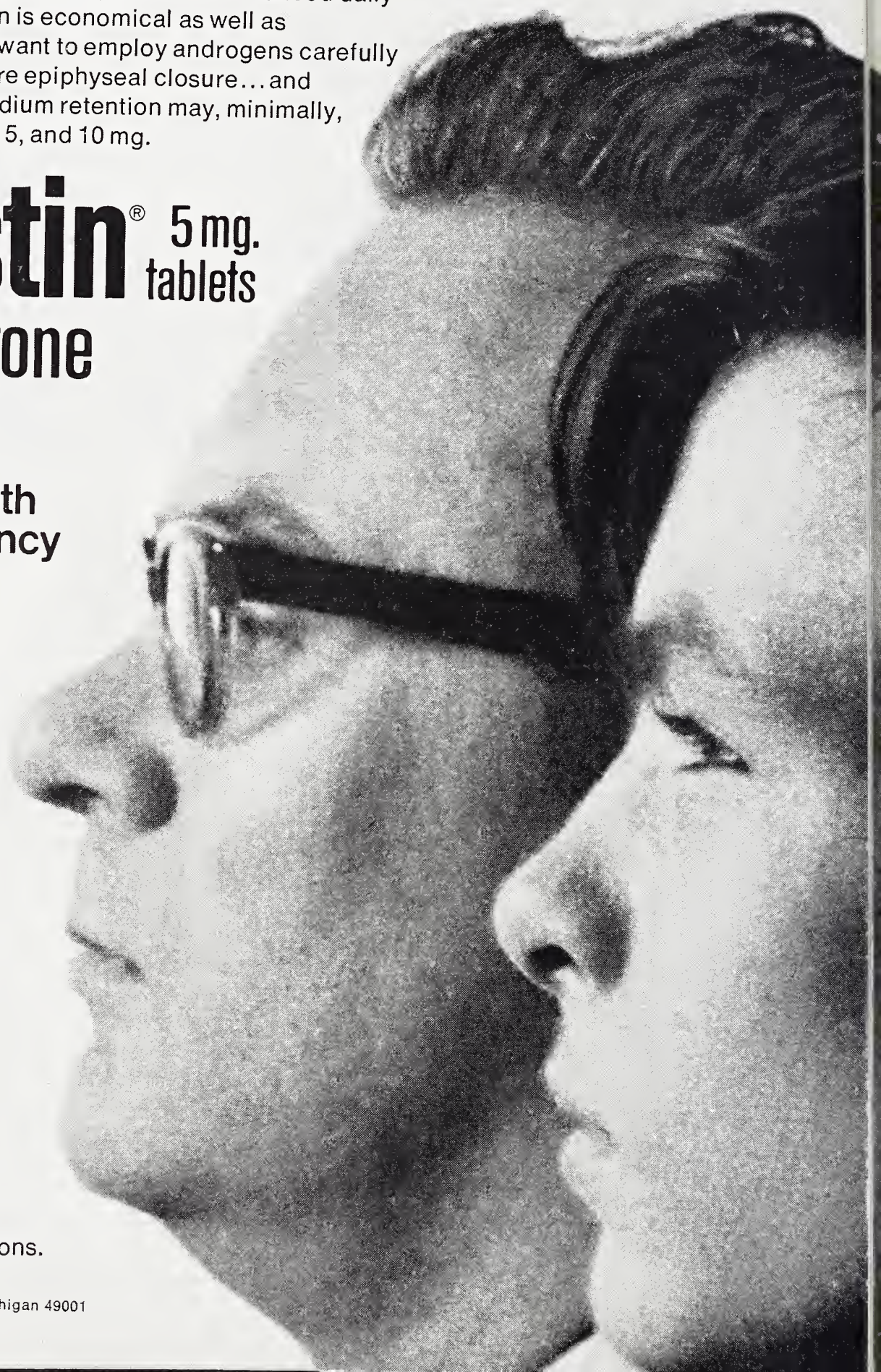
The program is acceptable for 23½ prescribed and 8½ elective hours by the American Academy of General Practice, is also accredited by the AMA Council on Medical Education, and is acceptable for credit toward the AMA Physician's Recognition Award.

Advance registration fee is $25.00 and may be mailed to IPMA, P. O. Box 5445, Madison, Wisc. 53705. For hotel reservations write IPMA Housing Bureau, 334 Royal Street, New Orleans, La. 70130.

Interstate is not a membership organization, but rather a non-profit educational association which annually presents a program of high quality of special interest to family physicians and internists. Any licensed M.D. may attend.

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Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.
Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.
Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.
Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.
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SBH Develops Alcoholism Program

The first steps toward the development of a comprehensive plan to combat alcohol abuse and alcoholism in Mississippi have been taken, according to Dr. Hugh B. Cottrell, State Health Officer.

The State Board of Health's move toward statewide mobilization for a coordinated effort against the various problems related to alcohol abuse follows its recent designation by Governor John Bell Williams as the state agency responsible for developing a state plan and supervising its administration.

With a single state agency charged with these responsibilities, Mississippi agencies, institutions and organizations will be eligible for federal funds under the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970," Dr. Cottrell pointed out.

The State Board of Health, he said, will have the responsibility of reviewing grant or contract proposals for projects and services to ensure that they will further the implementation of the overall plan, according to its established priorities.

"The State Board of Health has accepted the responsibilities delegated to us with full recognition that no one agency or group in the state has the capability to wage an effective single-handed fight against alcholism—a problem of pervasive impact, gigantic proportions and numerous dimensions," stated Dr. Cottrell.

The state health officer said that it is the goal of his agency "to develop a comprehensive coordinated program through a thorough, deliberate and systematic planning effort, involving existing public and private agencies and existing professional and lay community groups."

"Just as our state plan will be multifaceted," explained Dr. Cottrell, "so will our approach be multi-level, multi-disciplinary, multi-agency, multi-locational and multi-generational."

The State Board of Health has delegated the responsibility for developing the state plan to the Mental Health Services Division, headed by Dr. Nina Bess Goss-Moffitt, Dr. Cottrell said.

Pathologists Dedicate Educational Center

The recent dedication of the American Society of Clinical Pathologists' new Educational Center in Chicago marked a highly significant milestone in the development of this branch of medicine.

During the nearly 50 years since the society was formed at a medical meeting in St. Louis, on May 23, 1922, the membership has grown from 145 charter members to today's record high of more than 16,000, of whom some 6,000 are doctors of medicine and another 10,000 are medical technologists.

The American Society of Clinical Pathologists was established when clinical pathology had been recognized as a distinct specialty for scarcely a decade.

The charter membership of the ASCP founded the society to promote the practice of scientific medicine by a wider application of clinical laboratory methods to diagnose disease. Among its continuing goals have been the stimulation of original research, uniform standards for the performance of laboratory examinations, and constantly rising skills.

As a result the new Educational Center of the Society is the first building ever to be constructed by any medical group expressly for the continued education of its membership. Because of the Society's continuing education program literally tens of thousands of practicing physicians and medical technologists have studied either at regional and national meeting workshops, seminars, or in "at-home" courses to perfect still further their professional competence.

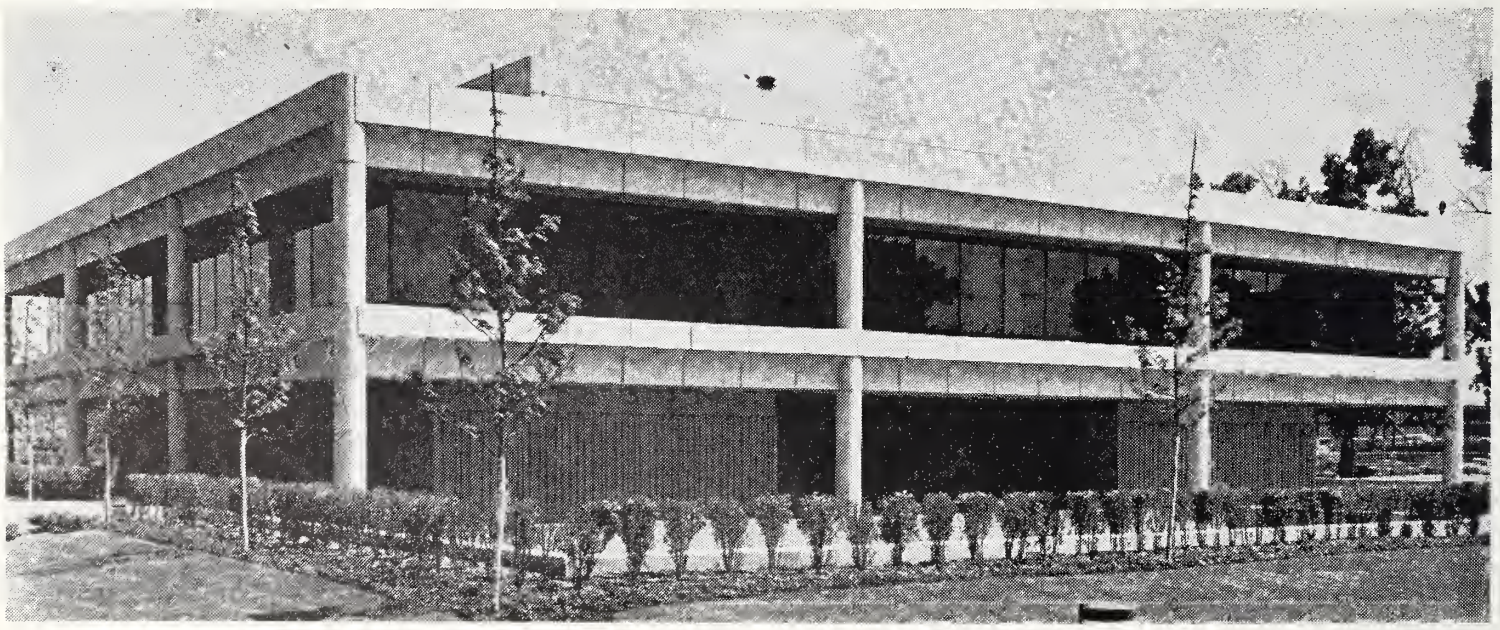
Although educational programs had been held by the Society since 1934, it was in 1956 that the Society approved the concept of organizing a program for the continuing education of the pathologist. The next year the Society's Commission on Continuing Education was formed, and in 1957 Dr. Coye C. Mason, a Chicago pathologist, became the first Commissioner.

By the next year under Dr. Mason's leadership 21 workshops had been held with a registration of 537. Ten years later 194 workshops were held at the Society's Annual and Interim Meetings, with total attendance of 7,421 participants. At these workshop sessions professional practitioners are brought up to date on such complex facets of their profession as biochemistry, cytology, hematology, histology, microbiology, immunology, morphology, virology and many others.

The clinical pathologist frequently provides the first definitive diagnosis of a patient's disease, working with the attending physician to identify the disease by use of such modern-day scientific tools as light and electron microscopes, cryostats, and batteries of sophisticated instruments for assaying the clinically significant components of many types of biological materials.

Seven pathologists have been awarded Nobel prizes for their pioneering work, including Sir Howard W. Florey, co-discoverer of penicillin with Sir Alexander Fleming, and Dr. George Hoyt Whipple for his work in discovering the value of liver therapy against pernicious anemia.

The establishment of the Society's Educational



The new $2,500,000 Educational Center of the American Society of Clinical Pathologists was dedicated June 17 in the West Side Medical Center of Chicago.

Center will make possible year-round workshops in the modern new laboratories of the buildings. Pathologists and medical technologists from all over the country will convene in Chicago every week for seminars and workshops designed to keep them abreast of the newest techniques in pathological diagnostic techniques.

But in addition to the workshops, year-round home study programs are also offered by the Society for continuing education. In the Check Sample program selected specimens are sent to physicians for their testing at home, thus enabling them to compare their results with a critique which identifies the unknown specimen and provides a review of current methodology.

Tutorial workshop programs, the monthly Summary Report, a library of audio-visual subjects on such subjects as hematology, immunohematology, microbiology and other fields of clinical chemistry are provided members for their home study. Various other manuals, tape recordings, improvement publications and a professional self-assessment program are other materials made available in the broad spectrum of the continuing education program.

CHAMPUS Authorizes Some Dental Care

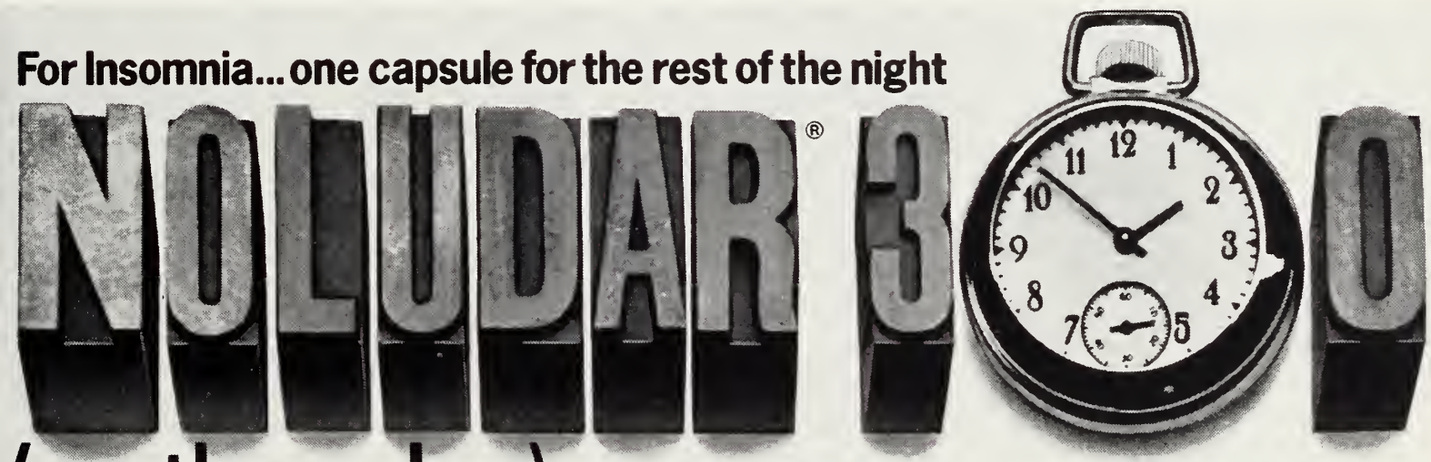
Dental care caused by an accident is now authorized in eligible beneficiaries under the CHAMPUS program.

The surgical removal of the pulp and the restoration of teeth, including necessary orthodontic work, in the case of wounds, fractures, lacerations and dislocations are authorized under CHAMPUS. Routine dental care, including cavity repair and teeth cleaning, is not authorized under the program.

Other services that are authorized, in addition to care related to an injury, include services required as a necessary adjunct to the treatment of a medical or surgical condition when the attending physician or dentist expect the dental care to exert a beneficial effect on the primary condition.

Also authorized for dependents of active duty personnel under the Program for the Handicapped is orthodontic care necessary to treat severe malocclusion.

For Insomnia... one capsule for the rest of the night



(methyprylon)

Before prescribing, please consult complete product information, a summary of which follows:
INDICATION: Relief of insomnia of varied etiology.
CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.
Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.
Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.
PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.
ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

Each capsule contains 300 mg of methyprylon.

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Acron Markets New Surveillance System

A new advance in electronic security devices which allows a premise to be monitored audibly has been introduced by Acron Corporation at the recent I.S.C. Exhibit at Chicago's Conrad Hilton Hotel. Called TELECOMMAND the unit is an audio surveillance instrument utilized to confirm intrusion and provide remote audio monitoring on a signal if intrusion is suspected.

The TELECOMMAND system is comprised of a highly sensitive microphone, coupled to a high gain audio amplifier. The amplifier output can be attached to a telephone in the area to be monitored by a standard two wire telephone cable. An associated unit, called the Interrogator is carried on the person of the security officer or other individual (e.g., homeowners, store owners, etc.). The amplifier can be interrogated from any outside telephone by simply dialing the telephone to which it is connected. Five separately coded frequencies are available, insuring maximum privacy of operation.

As the person is dialing, he holds the cigarette-pack-size Interrogator next to the mouthpiece of the telephone from which he is dialing. As he dials the last digit a special tone instantly activates the receiver at the site being monitored before the telephone bell can ring. In so doing, it automatically turns on the audio system, thereby opening the circuit and preventing the telephone bell from ringing and alarming the intruder.

There is no need to remove the hand-set from the telephone at the receiving end. The authorized calling party is now able to monitor the facility as long as he wishes. When finished, he merely hangs up. The receiving telephone is now in its normal operating mode and is ready to accept incoming calls.

TELECOMMAND cannot intercept a phone conversation because it is *NOT* a wire tap or normal bugging device. It has the specific function of confirming unauthorized entry *ONLY*. TELECOMMAND is sold to security dealers and law enforcement agencies for the purpose of crime prevention and detection only. No other use is intended or implied by the manufacturer.

A version of TELECOMMAND, called the VERIFIER is marketed by Acron for use with its emergency telephone dialers. It allows the authorities or central station to listen-in to the premise after the alarm message has been telephoned, confirming that the alarm was not false and determining the approximate number of people and the extent of the intrusion in progress. The unit is activated by the dialer itself and not from a remote source. TELECOMMAND operates on 110V ac and measures 5¼″ x 5¾″ x 1⅜″.

For complete details on the Acron TELECOMMAND, write Marketing Department, Acron Corporation, 1209 River Avenue (Route 9), Lakewood, New Jersey 08701.

Physicians Assistants Form Organization

The Physicians Assistant, newest professional on America's health team, has formally organized with the opening of a national office of the American Association of Physicians Assistants in Tampa, Fla.

The AAPA, under the guidance of Dr. Sanford Pinna, director, and Dr. Frank Norton, executive secretary, has embarked on a program to define precisely the roles of the P.A. in health care delivery systems and to expedite proper, effective assumption and maintenance of these roles.

"Health care delivery now lags far behind capability in many areas of the country," said Dr. Pinna. "The Physicians Assistant," he continued, "will be a key factor in bringing about grass roots delivery of optimum health care."

Key elements in the AAPA program will be: liaison with educational and governmental institutions and with employers; and in-service function-tailored education for members to provide continuous upgrading of their professional status.

The AAPA will coordinate its activities closely with the AMA and other physicians' organizations in order to promote achievement of common goals.

The AAPA has established an information center for members in which they are put in touch with universities and hospitals now offering formal training programs leading to certification. At present, there are approximately 20 schools and hospitals throughout the country offering such programs. A Physicians Assistants' Placement Bureau being formed will provide interested physicians and hospitals and prospective Physicians Assistants with a medium through which they may contact each other.

Applicants can obtain information about the AAPA and its activities by writing the American Association of Physicians Assistants, 1111 North West Shore Boulevard, Tampa, Fla. 33607.

..in the presence of spasm or hypermotility, gas distension and discomfort, **KINESED®** provides more complete relief:

- ☐ belladonna alkaloids—for the hyperactive bowel
- ☐ simethicone—for accompanying distension and pain due to gas
- ☐ phenobarbital—for associated anxiety and tension

Composition: Each chewable, fruit-flavored, scored tablet contains: 16 mg. phenobarbital (warning: may be habit-forming); 0.1 mg. hyoscyamine sulfate; 0.02 mg. atropine sulfate; 0.007 mg. scopolamine hydrobromide; 40 mg. simethicone.
Contraindications: Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.
Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.
Side effects: Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.
Dosage: Adults: One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms. Children 2 to 12 years: One half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

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(from the Greek **kinetikos,**
to move,
and the Latin **sedatus,**
to calm)

KINESED®

antispasmodic/sedative/antiflatulent

Spring peeper (tree frog, *Hyla crucifer*): this small amphibian can expand its throat membrane with air until it is twice the size of its head.

(5) To work cooperatively with private insurance, voluntary prepayment, and tax-supported medical care plans to provide for periodic and realistic budgeting of just and proper costs.

There are many things which a medical care foundation is *not:*

—It is not a union nor is it a closed shop where non-member physicians are excluded from normal practice freedoms and prerogatives.

—It does not and cannot affect the membership status of any physician in official medical organization.

—It does not and cannot affect the right conferred by licensure of any physician to practice medicine.

—It is not an insurance, prepayment, or government care program or financing mechanism. As a foundation, it doesn't have a dime except for at-cost income to support its activities, and this is derived from services billed to care financing sources.

—It is not the answer to every problem facing the health care delivery system today, but it *is* a delivery system that works in the hands of the medical profession.

The foundation's draft authority and quality review functions are responsibilities it is willing to assume. A stewardship accounting of these activities is made to the public, physician-members, care financing sources, and the sponsoring medical association. Membership in the foundation for physicians is voluntary and usually renewable annually. The MCF has two types of membership:

(1) *Administrative Members.* These members are appointed by the sponsoring association's Board of Trustees or are the Board members themselves, as is usually the case. They appoint the MCF's board of directors or trustees.

(2) *Participating Members.* These are the practitioners who voluntarily choose to avail themselves of the foundation's services, advantages, and usefulness as a private care delivery mechanism.

Philosophical Base. The medical care foundation is therefore an extension of the medical association consisting of those members who voluntarily desire to use it to preserve private practice patterns. It is obviously self-disciplined in its functions and purposes but really no more so than any ethical physician who accordingly disciplines himself. In practice, it has shown itself capable of making worthy judgments for and by physicians, and these judgments are accepted by care consumers and financing mechanisms.

Some few state medical associations possess the medical leadership, experience, personnel, and facilities characteristic of a medical care foundation without actually having one, and Mississippi is one such state with its CHAMPUS and peer review programs. We are years ahead of many associations in the development and successful implementation of the usual and customary fee concept and our ability to administer it under physician control.

The logical question now arises: Why have a medical care foundation when we already have peer review, medical care plan administration, trained personnel, and data processing and suitable office facilities? Why a foundation when we have successfully developed and implemented a usual and customary fee program? Why set up another organization to join?

The answer is simple: A medical care foundation can do those things which a medical society as such ordinarily does not do and in some instances, may not do. The MCF concludes contracts with corporations, management, employee representatives, and care financing sources to deliver medical care within a framework of mutually acceptable policy.

Second, the MCF is not only now accepted as a delivery mechanism but it will probably be the only such device acceptable under law in existing and proposed government care financing programs. Third, it can and does stand as a buffer between the private physician and the third party as the advocate of the patient.

The medical care foundation does not retail medical care. In the words of the stock exchange, it provides an "orderly market for fair trading." In President Brumby's words, it is an "honest broker."

Movement Toward MCF's. In the light of actions and pending developments among state medical associations, the Board believes that within 12 months an array of MCF's will be found in half of the states serving as many as 60 per cent of the practicing physicians and patients. It appears that the foundation is the best means of assuring equitability between the traditions of private practice and the physician-patient relationship with the world of their parties which are here to stay. The United Foundations movement is spreading rapidly within the organized profession.

The move to a medical care foundation for a majority of state medical associations is difficult, extensive, and costly. Most associations are without experience and administrative mechanisms for claims processing, payment, data processing, and related services. We have such capabilities,

and for Georgia, an association similar to ours, the conversion was easy. Their foundation's address is that of the state medical association.

Recommendation. Both the Council on Medical Service and the Board of Trustees have devoted time to study of medical care foundations during 1970-71. We are convinced of their merit and advantages, the limitation of commitment, soundness of concept, and benefits to all concerned. The Board therefore recommends that the House of Delegates authorize and empower it to create and establish the Mississippi Foundation for Medical Care under the control and sponsorship of the Mississippi State Medical Association within the policy framework presented in this report.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

This report outlines the work of the Board in devoting much study and deliberation to an association-sponsored medical foundation. We are aware that these foundations are being developed in many states under state medical association sponsorship as a means for providing physician control and administration of medical care financing mechanisms.

The foundation proposed would have the staff and capabilities for conducting peer review as to care quality and adjudicating and paying claims under medical supervision. The foundation would have two types of membership, administrative members who are those who appoint the board of directors of the medical care foundation and participating members consisting of those physicians voluntarily choosing to avail themselves of the services of the foundation.

Your reference committee approves and concurs in the proposal of the Board of Trustees. We recommend that the House of Delegates authorize and empower our Board of Trustees to proceed to create as a legal entity and a corporation not for profit The Mississippi Foundation for Medical Care under association sponsorship and control. We recommend that our Board of Trustees be the administrative members of the foundation and the incorporators.

Your reference committee emphasizes that participation in the Mississippi Foundation for Medical Care is purely voluntary and that the decision on the part of an individual physician not to participate in the care foundation in no way affects his practice status or his membership or non-membership in the Mississippi State Medical Association. We believe that a medical care foundation under our supervision and control will stand as an advocate of the patient and a buffer between the physician and the third party. We request that the Board of Trustees keep the membership informed as to developments in creating the new foundation.

The chairman of the reference committee moved adoption of the report.

Dr. George D. Purvis of Jackson moved that the third paragraph of the report of the reference committee be amended by deleting ". . . to create as a legal entity" and all words thereafter in the paragraph, substituting therefor "to inform the membership of MSMA regarding the Mississippi Foundation for Medical Care. If action of the House of Delegates is deemed advisable before the next regular session of the House of Delegates, a special, called meeting of the House of Delegates should be called."

The motion to amend was seconded by Dr. Charles M. Moore of Philadelphia.

Dr. Purvis and Dr. Moore spoke for the amendment. Speaking against the amendment were Drs. Mal S. Riddell, Jr., of Winona, J. T. Davis of Corinth, H. C. Ricks, Sr., of Jackson, Millard S. Costilow of North Carrollton, Norman W. Todd of Newton, Charles R. Jenkins of Laurel (who stepped aside as chairman of the reference committee to speak on the floor as a delegate), Guy T. Vise of Meridian, and Paul B. Brumby of Lexington. Dr. Angus M. McBryde of Sumrall made an inquiry on the pending business, and Dr. Ricks called for the question.

The Speaker put the motion to amend which was defeated. There being no further discussion, the Speaker put the main motion to adopt the report of the reference committee.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT C OF THE BOARD OF TRUSTEES

Quality Care (Peer Review) Program. In April 1970, the then-president of the association, Dr. James L. Royals of Jackson, appointed an *Ad Hoc* Committee on Peer Review. More than any other single individual among us, Dr. Royals gave impetus and definition to this important field of activity in our association. In his presidential address, he stated in part:

"Within our own ranks, we must develop a working system of peer review as an effective instrument of self-regulation. The unacceptable alternative, and it is virtually upon us, is submission to third parties who would sit in judgment upon the quality of care and the price paid for it.

"Physicians are best equipped to make these judgments, but we must make responsible and worthy judgments if we are to have them accepted."

At the 102nd Annual Session, the Board of Trustees submitted Supplemental Report E, subject: Peer Review, to the House of Delegates outlining a program and recommending that the former Grievance Committee be abolished and that a state association Committee on Peer Review be established as a constitutional body. The House approved the recommendations and the board implemented the program under the new committee.

During the 1970-71 association year, the committee met on six occasions. In addition, it conducted two meetings of third party representatives and about eight major staff conferences, many of which were conducted by the chairman in behalf of the committee. The committee has represented us at regional and national conferences and field work has been performed in visiting and studying other state medical association programs.

Third Parties. The committee established effective working relationships with virtually all third parties and care financing sources in Mississippi. Meetings were also conducted with regional and national representatives of some. Included are:

(1) Health Insurance Council and Health Insurance Association of America, representing 90-plus per cent of all commercial companies writing health insurance.

(2) Blue Cross-Blue Shield.

(3) Travelers Insurance Co., as the carrier for Part B Medicare in Mississippi.

(4) CHAMPUS, as represented by our association.

(5) Mississippi Medicaid Commission.

(6) Social Security Administration, Bureau of Health Insurance, Medicare.

(7) State Board of Health, Health Insurance Unit, for certification of inpatient facilities for Medicare and Medicaid and utilization review.

Program Development. In the process of program development, the committee utilized full time services of the third executive and other resources made available by the expanded program of services approved in 1970. The committee embarked upon a program of self-education as it simultaneously worked to develop definitions, guides, two-way lanes of communications with many areas of expertise, and rapport with medical care financing mechanisms. Two key projects developed early in the program are:

(1) Drafting and publishing of guides for component medical society committees.

(2) Establishing communication with third party financing mechanisms and care programs.

It is important to recognize that our program was well under development when the now-famous Bennett Amendment (Amendment No. 851) to H.R. 17550 was introduced in the Congress. AMA's first Medicredit bill also included a review mechanism. Initially, the Bennett proposal was objectionable to the medical profession, but it was moderated and made generally acceptable after forceful testimony by AMA. Our program has always been and now remains medically-oriented.

Adjunctive Structures. Of greatest importance in adjunctive and supportive structures erected by the committee are specialty consultants, because they alone can supply the needed expertise needed in appraisal and evaluation of care quality. The committee has requested the specialty societies in our state to appoint panels of three consultants each for this purpose. Fifteen of the 20 specialties are represented by societies in Mississippi.

Quality Criteria. Our 1970 policy defines peer review as educational and corrective, never punitive. This policy has been amplified to declare that the heart of peer review is the evaluation of care quality, always with the first and uppermost objective of improving quality and fulfilling the primary role of making this an educational function.

In the pursuit of this goal, the committee has initiated action to develop quality criteria manuals of and for Mississippi. These will be guides and not standards to consider optimum care criteria for in- and outpatients. The assistance of the Regional Medical Program has been secured for development of inpatient criteria, while the cooperation of the Mississippi Medicaid Commission with its claims data is being secured for outpatient information.

In addition to the criteria manual project, RMP is also assisting in development of a practice review team of qualified specialists who, on voluntary invitation from a practicing physician, will go into his practice environment and review with him his practice on a quality evaluation basis, purely as an individual, confidential, educational service. A statewide workshop is being organized on care quality, and we anticipate announcement of meeting dates later in the year. Finally, a system of district utilization review consultants is being organized to assist medical communities on invitation where the local utiliza-

tion review process tends to stagnate or where a particularly difficult case is encountered.

Position Summary and Recommendations. In the development of this extensive program, three primary concepts have emerged which the committee offers as policy with the full approval of the Board of Trustees:

(1) Peer review (as previously designated) should be conducted at state association level. It is a complex, extensive, and arduous activity field not easily adapted to and implemented at component medical society level.

(2) The first objective and primary thrust in this field must be care quality evaluation, education, and improvement. This goal and objective transcends all other aspects of the program.

(3) If this activity is to be considered just another name for grievance processing, fee review, and utilization review, then it is not worthwhile in the context of the massive effort and financing it requires.

We caution against orienting this activity in such emotion-charged areas as fees, performance of an individual physician in a given case, and harsh utilization review policies. We feel that the program should at all times be positive, educational, and nonabrasive. In these connections, the most productive application of this educational effort is at the hospital staff level.

The Board of Trustees in now assisting the committee in the development of staff services for this program which will involve screening in medical care plans and making full use of data processing. This will be anonymous as to physician and patient, and we hope to extract, digest, collate, and present arrays of useful data for study by the committee who will probably see only a very small percentage of cases in detail. We hope to publish these data and hopefully to be able to furnish hospital staffs with extracts on their own respective cases in furtherance of the educational process and service.

Overall, the program of the committee is comprehensive, varied, positive, and useful. It could not have been developed without the additional financial support provided by the House of Delegates in 1970. The Board of Trustees associates itself in the expression of appreciation by the committee and commends each member, especially Dr. Millard S. Costilow, the chairman. The American Medical Association has requested permission to include a portion of the committee's published guides in the new AMA Peer Review Manual. Dr. Costilow has been invited to serve as moderator for the AMA National Conference on Peer Review, Chicago, May 21-22, 1971.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

We commend the work of the Board's Committee on Peer Review and applaud its diligence, dedication and energy demonstrated by devotion of substantial amounts of time and work during the 1970-71 association year. We approve the program as reported to this House of Delegates and request that its program be incorporated in the work of the Mississippi Foundation for Medical Care as the foundation is developed. We recommend adoption of this report.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT D OF THE BOARD OF TRUSTEES

Annual Session. At the 102nd Annual Session in 1970, the Board presented Supplemental Report A in which constitutional requirements and House of Delegates policy relating to the annual session were reviewed. Implementation of Resolution No. 9, subject: Scheduling the Annual Session, 1969, fixing new dates to avoid conflicts with Mother's Day and municipal elections in the year held was reported. The House approved the new dates as follows:

Annual Session	*Dates*
103rd	May 3- 6, 1971
104th	May 8-11, 1972
105th	Apr. 30-May 3, 1973
106th	May 6- 9, 1974

All annual sessions, under a policy adopted by the House in 1967, were scheduled to be conducted on the Gulf Coast.

102nd Annual Session. In conducting its critique of the 102nd Annual Session, 1970, the Council on Scientific Assembly discovered dissatisfaction with the hotel facilities employed. The council recommended that the Board of Trustees appoint an *ad hoc* committee to survey other Gulf Coast convention facilities with a view toward selecting a new headquarters hotel. The Board responded and appointed a committee consisting of a past president, an incumbent member of the Council on Scientific Assembly, and a section officer.

The committee conducted an on-site survey of Coast convention facilities, recommending to the Board that the new Sheraton-Biloxi be utilized after the 1971 annual session. Subsequently, the Board was informed that this new convention center would be open and available for the present annual session. The recommendation of the committee to terminate contracts after 1971 with

the former headquarters hotel was augmented by Board action to effect termination at once. A contract was concluded with the Sheraton-Biloxi for the 1971 annual session and options were taken on the dates we have selected for 1972, 1973, and 1974. The Sheraton-Biloxi was opened in February 1971 after having begun partial operation in January.

103rd Annual Session. The present annual session is the first major, sell-out convention conducted in the new Sheraton-Biloxi, a Mississippi-owned and operated franchise of this distinguished national organization. While the hotel is staffed with competent and experienced executives and supervisors, its internal organization as a functioning entity is still being perfected. Our association, too, is without previous experience in planning and conducting a convention of such major proportion in the few facility. The Board therefore endorses the comment of the Council on Scientific Assembly in requesting the patience and indulgence of all should minor dislocation and difficulties arise.

Recommendation. The Board of Trustees recommends adoption of the dates of May 4-8, 1975, for our 107th Annual Session. We recommend that a contract with the Sheraton-Biloxi for 1972 be concluded, that options for the 1973 and 1974 annual sessions be renewed, and that an option be sought for 1975.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

We concur in the recommendations of the Board of Trustees on the scheduling of annual sessions for 1972, 1973, 1974 and 1975. We are pleased with the facilities and services furnished by the Sheraton-Biloxi and we recommend that the House of Delegates authorize the Board of Trustees to conclude a contract for the 104th annual session of our association at the Sheraton-Biloxi, May 8-11, 1972. We recommend that options on the 1973, 1974 meeting dates be renewed with the hotel and we recommend that an option be sought for May 4-8, 1975 for our 107th annual session.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT E OF THE BOARD OF TRUSTEES

Continuing Education and Allied Health Professions. The work of continuing or postgraduate education, training and status of allied health professions, and licensure is assigned to the Council on Medical Education which reports, under the requirements of the By-Laws, to the Board of Trustees. In presenting the work of the council to the House of Delegates with our endorsement and approval, the Board of Trustees warmly commends the Council on Medical Education and especially its chairman, Dr. William O. Barnett of Jackson, who retires from membership on the council by reason of having served the constitutional maximum of three consecutive terms.

Continuing Education. The four-facet program of continuing education in Mississippi, jointly sponsored by the University Medical Center and the Mississippi State Medical Association through the Mississippi Postgraduate Institute in the Medical Sciences, has been expanded and accelerated its programs during 1970-71. The on-campus intensive postgraduate program for physicians progressed on schedule during 1970 when cancer, GI, EKG, cardiorenal, stroke, and pediatrics courses were offered, and 20 physicians were trained.

Plans were made to expand this major activity to serve 40 physicians in 1971, and 43 are enrolled. The addition of the Ole Miss Medical Alumni House on the UMC campus has greatly assisted in this program. We still look forward to the day when the Postgraduate Institute will have its own building in the growing campus complex.

Second, the circuit course program has been continued with wide and representative geographic distribution, including the Gulf Coast, Meridian, Greenville, and Tupelo. A regular monthly feature in our Journal supports this aspect of the program. Third, we have continued the on-campus, one-time seminars for many disciplines, and among physicians, attendance has increased to an average of 20 to 30 in each of the seminars except for the major presentations which register even more.

Fourth, the Institute has developed programs of continuing education for allied health professions and medically-related fields. These include training projects for nurses, medical technologists, medical social workers, medical library personnel, physicians' lay medical assistants, and we are planning courses for hospital trustees. Both the Council on Medical Education and the Board of Trustees earnestly solicit the continued support of the profession in this endeavor. Our UMC-based continuing education programs are approved and accredited by the American Medical Association.

Records Project. About 20 years ago, the American Academy of General Practice recog-

nized the importance of continuing education and pioneered in postgraduate training requirements. Each AAGP member must undergo 150 hours of training every three years as a membership qualification. In 1969, the state medical association adopted minimums for postgraduate recognition which are incentive-oriented, requiring 440 hours each four years for academic recognition. Obviously, accurate, central recordskeeping is important in these programs.

In 1969, the American Medical Association established the Physician Recognition Award, an incentive-oriented program, providing recognition for undergoing 150 hours training in three years. AMA has stated that state medical associations able and willing to do so may be the official repositories for training records and are empowered to certify postgraduate attainment and credit for physicians.

On recommendation by the Council on Medical Education, the Board of Trustees has acted to have our executive office assume this responsibility effective July 1, 1971, retroactive to Jan. 1, 1971. The records will be maintained through the computer as a service to all physicians, and we will make appropriate certifications in behalf of participants to AMA for the Physician Recognition Award, to any and all specialty societies for credit as in the case of AAGP, and to our own Postgraduate Institute for the Mississippi program. We anticipate developing the capability of furnishing a "transcript" to each participating physician annually in addition to certification.

Physicians' Assistants. During the year, the council has made extensive studies of training programs for physicians' assistants, a new, growing, and important allied health profession. Training programs range from the eight months Medex project in four medical schools where former military medical corpsmen are reoriented to private practice environments through the Duke University program of two years to the Colorado program of four years and the awarding of a baccalaureate degree. The council has participated in meetings and conferences with educators and representatives of other medical schools engaged in this training. Further evidence of recognition is found in the offering of professional liability insurance, including our own St. Paul program, for physicians' assistants who have medical school training.

The council has offered the following policy guides in connection with physicians' assistants which the Board of Trustees approves:

(1) The adequately trained physician's assistant is needed and the association should approve and support this field.

(2) In conferring this approval and support, specific restraints on activities of physicians' assistants should be imposed, and the physician's assistant should occupy only a dependent, supervised function, never functioning independently.

(3) To qualify for association approval and support, physicians' assistants in Mississippi should meet stated training minimums and requirements.

(4) The physician's assistant should not be licensed but rather should be registered with the State Board of Health.

The Board recommends that the Council on Medical Education's policy guides be approved by the House of Delegates and that the council be authorized and directed to develop specifics within this frame of reference.

Midwives. In most nations of the world, midwives perform a large majority of normal obstetrics, and in the United States, fewer and fewer physicians do obstetrics. Both the council and the Board are aware of and do not endorse "granny" midwives who have historically been on the medical scene in our state. But we do feel that there is potential and promise of new and expanded health services manpower in the nurse-midwife, particularly the degree nurse with postgraduate training in a university center. This concept bears the endorsement of the American College of Obstetricians and Gynecologists.

The Board has asked the Council on Medical Education to study this issue, developing policy recommendations on nurse-midwives, even to the extent of recognizing them as obstetrical assistants after completion of sufficient training. We have asked that policy recommendations include training minimums, legal status, the role of the midwife in the hospital, and admission policies for patients to be delivered by nurse-midwives or obstetrical assistants. The Board and council believe that these allied health professionals should function with the support of physicians.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee approves this report which informs us that our executive office will soon initiate a records-keeping service for physicians' credit in postgraduate or continuing education. We also approve the basic policy outline on physicians' assistants as proposed by the Council on Medical Education and approved by the Board of Trustees. We request that training minimums and other aspects of this program be developed within this policy framework by the Council on Medical Education.

We approve the proposal on nurse midwives

or obstetrical assistants and ask that policies relating to their training, function and legal status be developed by the Council on Medical Education after referral of this recommendation by the Board of Trustees. We approve the report and recommend its adoption.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT F OF THE BOARD OF TRUSTEES

Mississippi Hospital Association and Extern Program. Early in the 1970-71 association year, President Paul B. Brumby and Mr. Lowery Woodall of Hattiesburg, president of the Mississippi Hospital Association, initiated a series of president-to-president meetings in behalf of liaison and constructive relationships between the two associations. At the same time, the executive offices of MSMA and MHA initiated a new exchange program in which each kept the other fully informed as to programs, projects, and activities. Counterpart members of each association met with official bodies of the other.

We discovered new areas of mutuality while recognizing that as mature, realistic, and honorable individuals, we can discuss differences with forthright candor. We also recognized that in certain areas—and legislation was the most important—we can accomplish more together than both can individually accomplish alone.

Our respective Boards adopted a liaison policy assigning these responsibilities at presidential level. Further, counterpart representation among official bodies of each association was encouraged, and the executive offices were authorized to initiate a close exchange program to coordinate activities and programs of mutual interest.

Summer Extern Program. In 1969, the Oxford-Lafayette Hospital pioneered in conducting a summer extern program with the in-institutional training of a Mississippi medical student.

Critiques of the project showed promise and value, and a joint program for 1970 was organized among the University Medical Center and the state medical and hospital associations. The hospital association organized the program by communication to hospital management. The medical association communicated with chiefs of staff in the 128 member institutions of the hospital association, while UMC encouraged and assisted the Student American Medical Association Chapter, comprised mostly of freshman and sophomores, in program implementation. The two associations sponsored travel to the AMA Clinical Convention for Tom Allen, the student chairman of the project, designated by SAMA as "Medical Education—Community Oriented" or MECO..

The purposes of MECO are to afford the medical student clinical experience in the local medical community and to encourage him to remain in his state to practice upon completion of his training. We are pleased to report participation by 28 hospitals in the 1971 program which will offer structured training of 10 weeks duration for 40 Mississippi externs under the direct supervision of the medical staff.

Curriculum. Each hospital staff prepared its own program which consists of 10 weeks training. There is weekly rotation as the extern experiences exposure of all aspects of hospital service, but emphasis is placed on clinical aspects of inpatient care. He is instructed in performance of routine procedures based upon the level of medical education and competency. They are regarded as trainees, not mere part time summer help or orderlies.

Where possible, the externs will follow individual patients and are permitted to make rounds with their preceptors. Specific members of the medical staff are identified to provide guidance for the extern. They are on call for observation of interesting cases of teaching value. The program is flexible, and a portion is devoted to non-clinical aspects of the hospital, i.e., administration, medical records, community relations, and computer utilization. The sponsoring institution provides a stipend of $75 per week and makes arrangements for the extern's room and board.

Assignment of externs was made through a matching program of extern positions and applications from the students. The state medical association performed staff work for the project and supported the SAMA committee.

Observation. As a portion of the association's program of expanded activities, the Board of Trustees believes that there is merit in the extern program both as to value in medical education and in encouraging our medical graduates to remain in our state. We cite this as an example of the constructive work which can be achieved by our young medical students and the UMC SAMA Chapter. We commend and applaud the Mississippi Hospital Association without whose support, interest, and leadership the program would not have been possible. The Board looks forward to conducting a searching critique of this project, and we will report to the membership.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

We commend our President, Dr. Brumby, and

the Board of Trustees for the constructive liaison conducted with the Mississippi Hospital Association during 1970-71 and we approve the summer extern program (MECO) which has been established in partnership with the hospital association and the University Medical Center. We believe that this program will be useful to our medical students, that it will encourage them to practice in Mississippi after their training has been completed, and that the interchange between the externs and the hospital medical staffs will be useful. We recommend adoption of the report.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT G OF THE BOARD OF TRUSTEES

Legislative Activities. After the unsuccessful and difficult experiences in the 1970 Regular Session of the Legislature, the House of Delegates authorized a greatly expanded program of legislative activity as a major part of the overall program of expanded services. The House acted to provide financing and staff for this endeavor and adopted specific instructions for its implementation under the Board's responsibility. The program was carried out by the Council on Legislation whose members have the commendation and appreciation of the Board of Trustees.

The new legislative program included regular and frequent communication to the membership, frequent meeting of the Council on Legislation, daily staff representation at the Capitol, close relationships with committees of the House and Senate considering health-related legislation, continuation and revitalization of the Emergency Medical Care Unit, and a project to encourage greater physician participation in legislative affairs.

The Board conducted meetings and conferences on implementation of the program and dedicated sufficient financing to assure its support. Detailed instructions, recommendations, and referrals were given to the Council on Legislation which embarked on the most active year of its history.

Communications. The Executive Secretary was authorized and instructed to initiate a special weekly newsletter, "Mississippi Medical Legislative Report," since popularly called the Blue Sheet, in December prior to the convening of the 1971 Regular Sesion. The four-page publication was issued weekly and sent by first class mail to all members for receipt by Friday mornings.

Of about 3,100 introductions, we followed approximately 300 bills with direct or indirect health and medical implications. About 250 bills were followed in the Blue Sheet with condensed narrative reporting on activities related to health and medical legislation. A conscious effort was made by the council and executive staff to avoid general reporting on the Legislature, and the publication was as medically oriented as we could make it. The final issue for 1971 was published last month after the Governor had acted on bills sent to him for signature.

Council and Staff. The Council on Legislation has conducted frequent meetings during the 1970-71 association year. On two occasions during the 1971 Regular Session, the council met with and entertained at dinner the Committees on Public Health of the House and Senate. There was weekly—and sometimes daily—communication among the council, association leadership, and executive staff.

The council made decisions as to the need for and extent of formal representation on pending matters. Formal testimony was presented by physicians selected for their special knowledge and expertise. In addition, we filed position papers and wrote frequent letters on association positions. We had daily representation at the Capitol by one, and usually two, staff executives. Communication with leaders of the House and Senate was close and frequent. In addition to representation, we also performed services for the Legislature, making a major study of physician participation in Medicaid, conducting the EMCU, and performing a variety of research and coordination tasks.

EMCU. We were again fortunate in retaining the full time services of Mavis Barlow, R.N., of Jackson as our staff nurse at the Emergency Medical Care Unit. Doctors-of-the-Day were signed up through the Blue Sheet, and the response has never been greater. During the 90 day session, there were 660 patient visits to the unit. Each DOD was presented to the House and Senate by his home delegation.

Legislative Program. In sharp contrast with the unpleasant experiences of 1970 when there were efforts to liberalize civil statutes on professional liability, license cultists, and enact patently antimedical laws, the 1971 session was a virtual opposite. *Not a single major measure opposed by the association was passed in either chamber.* Many measures we sponsored or supported were passed. We lost some good bills, too. Among four major legislative objectives adopted by the House of Delegates at the 102nd Annual Session and actions on them were:

(1) Enactment of a limited institutional licensure law for foreign medical graduates, passed and signed by the Governor.

(2) Air ambulance (helicopter) services, passed and signed by Governor.

(3) Amendment of the abortion laws to permit therapeutic procedures for medical indications, lost on the calendar after the bitter fight over a sky-blue abortion bill which we opposed.

(4) Statutory standards for practitioners to eliminate to the maximum possible extent cultists, withdrawn after easy defeat of chiropractic licensure legislation and assessment of the risk of a legislative fiasco in extensive amendment to the medical licensure laws.

A fifth objective was achieved administratively and later confirmed by legislative action. This was establishment of the North Mississippi Retardation Center at Oxford which has been funded.

Members of the House and Senate told our council and officers and Trustees that physician interest in legislation was substantial. They reported informed discussion with physicians at home and said that they appreciated this interest and advice and frequent communication. The Board emphasizes again that decisions on legislation are made at home in the representatives' and senators' districts with leadership and support in Jackson. But the Jackson activities alone cannot make a successful program.

The council and Board feel that the ultimate expression for the membership's good work was contained in H.R. 17, introduced by the distinguished Speaker of the House, Hon. John R. Junkin of Natchez, thanking the association for "advice and assistance to the 1971 Regular Session" and expressing appreciation for the EMCU program. Mr. Junkin presented an engrossed copy of the enactment to the association.

1972 Program. Both the council and Board of Trustees recognize that there is unfinished business in our legislative program with new challenges in 1972 when we will have a session of 125 days, as permitted for a new Legislature and new Governor. Mandates will come from the present annual session, and we will continue to seek enactment of measures still on the agenda.

We are deeply concerned over the growing attacks on the State Board of Health from various quarters in state government. A total of 21 bills was introduced in the 1971 session which, if enacted, would have been detrimental to the Board of Health. One series would have abolished the present board and replaced it with an 11-member body consisting of only one physician, other health representatives, and consumers. Still another series would have redesignated and redefined public health activities with major changes.

Virtually all of these bills had two things in common: There were either overt proposals or indirect actions to convert the State Board of Health into a multidiscipline, consumer-oriented agency, and medical licensure would have been separated from the Board of Health. Both the Council on Legislation and the Board of Trustees are giving this matter continuing attention and study. Close liaison has been and will be maintained with the State Health Officer and the Board of Health.

Finally, the Board of Trustees expresses deep appreciation to the Council on Legislation and to the membership for this unprecedented response to a vital need in behalf of the health of our state and the profession. We realize that without financial and personal support the program and the attendant successes would not have been possible. We ask your continued support.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee commends and applauds the 1971 legislative program of your state medical association. This highly successful program which is confirmed by enactment of H.R. 17 introduced by the distinguished Speaker of the House of Representatives, Honorable John R. Junkin of Natchez, resulted from dedicated and continuing work by the Council on Legislation and staff. But, it would not have been possible without participation by members in the local communities of our State. We approve this program and ask that it be continued. We are also aware that the conduct of this program entails expense and the House of Delegates wisely provided for this in the 1970 actions on financing this activity. We approve the report and recommend its adoption by the House of Delegates.

The chairman of the reference committee moved adoption of the report.

Dr. Mal S. Riddell, Jr., of Winona moved to amend the report by inserting before the last sentence "These members along with public spirited members of the House and Senate worked together as a team in the best interest of the people of the State of Mississippi." The amendment was seconded by Dr. Eldon L. Bolton of Biloxi.

There being no discussion, the Speaker put the amendment which was adopted. The report of the reference committee was adopted as amended.

SUPPLEMENTAL REPORT H OF THE BOARD OF TRUSTEES

Medical Student Membership. At the 102nd Annual Session, 1970, the House of Delegates

adopted Resolution No. 8, subject: Medical Student Membership, which provided for creation of a degree of membership for junior and senior medical students enrolled in AMA-approved medical schools in Mississippi and authorized creation and chartering of a special component medical society where the student members might conduct their own society affairs, including election of their officers and voting delegates to the Mississippi State Medical Association. The Board of Trustees was authorized and directed to implement the resolution.

Action of the Board. To implement Resolution No. 8, the Board appointed an *Ad Hoc* Committee on the University Medical Society consisting of an officer, a Trustee, and a faculty member of the University Medical Center. The committee met with student leaders of the junior and senior classes, offering advice, assistance, and services. Our executive staff also assisted and conducted a number of meetings with the student leaders. A simplified, brief application for membership was developed and mailed to each junior and senior by the president of the UMC student body.

The students drafted their own society constitution and by-laws which have been approved by the Board and which are in consonance with those of the state medical association. In all instances as to organization, the students have been given responsibility, and this good work is theirs.

We have received 95 applications for membership which are being processed effective with the charter date, May 3, 1971. The society has conducted its organizational meetings, adopting its constitution and by-laws and electing its officers. There are two delegates being seated, in accordance with the usual apportionment.

Student Representation. A number of student leaders are deserving of commendation for their exercise of leadership and responsibility. Outstanding among them have been Donald J. Blackwood of Drew, president of the student body; William J. Gibson, Jr., of West Point, the first president of the University Medical Society; and Paul B. Welch of Laurel, one of the delegates to the Mississippi State Medical Association. Mr. Gibson also sits as a delegate, and both he and Mr. Welch are juniors.

These gentlemen represent the next generation of our profession, and we have reason to take pride in them. The Board and general officers feel that our confidence has been well-placed, and we welcome them as colleagues, looking forward to the day when they shall have earned the full mantle of medicine.

The Board of Trustees stands ready to continue the sponsorship assigned to it by Resolution No. 8 and to work with the society and the new junior class this fall.

Charter. The Board felt that it was appropriate to confer the charter to the University Medical Society on an occasion when representatives of all components of the association could be present, and we have arranged an appropriate presentation by the presidents of the American Medical and Mississippi State Medical Associations.

SPECIAL CEREMONY

The Speaker then invited the Presidents of the state and American Medical Associations, Drs. Brumby and Bornemeier, and the delegates from the University Medical Society, Messrs. William J. Gibson, Jr., of West Point and Paul B. Welch of Laurel, to the podium. Drs. Brumby and Bornemeier formally chartered the society and presented the engrossed charter to Messrs. Gibson and Welch. Mr. Gibson is also president of the society. Each responded with an expression of appreciation, and the House of Delegates gave the new society an ovation.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

We are gratified to see the resolution creating the University Medical Society which juniors and seniors carried to fruition by the Board of Trustees, and we appreciated the opportunity of witnessing the chartering of this society by the presidents of our association and AMA. We commend the two student delegates, Mr. Gibson and Mr. Welch, and congratulate them on their exercise of leadership. We wish these young people well and ask that the Board of Trustees continue in its sponsorship of this new component of our association. We approve the report and recommend its adoption by the House of Delegates.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT I OF THE BOARD OF TRUSTEES

Capital Improvement Program. During the closing days of the 1971 Regular Session of the Legislature, a group of senate leaders approached the association to discuss long-term capital improvements for our eight state colleges and universities and the medical center. The senators recognize that most such capital improvement programs have been structured on the fallacy of full appropriations from general funds which often result in hasty design and construction to accommodate fiscal year expiration deadlines, denial of operating funds needed in the same year, and

lack of long-range planning for optimum capital improvements.

The senators propose a 10-year program for $185 million in capital improvements for the eight institutions of higher learning and the University Medical Center. The latter has developed a carefully phased long-range development program for attainment of our medical education goals in the state.

We also recognize that without sound premedical education, our medical center program will be at uncomfortable disadvantage. Full development of higher education is vital to our state and to the ultimate development of needed medical manpower.

Despite the merit of this proposal, the Board of Trustees was willing to initiate a report to the House of Delegates only if requested to do so by the University Medical Center. The proposal was given to Gen. Blount, Dean and Director of the University Medical Center. He consulted the Chancellor and with his approval expressed to the Board his interest in the proposal as well as the priorities for the medical center complex capital improvement program. Gen. Blount has asked the support of the association in a formal written request based on the priorities established by the University Medical Center Long-Range Planning Committee.

Recommendation. The Board of Trustees therefore commends this long-term capital improvement program for institutions of higher learning in Mississippi to the House of Delegates with approval in principle. We recognize that much work and study must be devoted to definition of specifics and to final implementation. We encourage discussion, constructive suggestions, and thoughtful deliberation to the end that the association may contribute to the work of improving higher learning in Mississippi.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

This report recommends association approval and support of a 10-year, $185 million improvement program for the eight institutions of higher learning in Mississippi and the University Medical Center. Your reference committee was privileged to hear two distinguished Mississippians discuss this matter, Chancellor Porter Fortune of the University of Mississippi and Honorable Corbett Patridge, a member of the State Senate.

We add our endorsement to that of the Board of Trustees and recommend approval by the House of Delegates, requesting that the Board support this program when it is presented to the Legislature as regards the University Medical Center and the institutions of higher learning conducting premedical educational training.

The report of the reference committee was adopted.

SPECIAL PRESENTATION

On motion by Drs. Mal S. Riddell, Jr., of Winona and Raymond S. Martin, Jr., of Jackson, seconded by Dr. H. C. Ricks, Sr., of Jackson, the privilege of the floor was extended by unanimous consent to Mrs. Guy T. Gillespie, Jr., of Jackson who addressed the House of Delegates. Mrs. Gillespie described the proposed Mississippi Health Expo I, requesting sponsorship of the association. This health education project is scheduled to be presented in the Mississippi Coliseum at Jackson Oct. 1-3, 1971, and the proposal has been approved by the Board of Trustees.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee was privileged to hear Mrs. Guy Gillespie of Jackson describe plans for the Mississippi Health Expo I scheduled to be conducted at the Coliseum at Jackson October 1-3, 1971. The Board has previously approved this program, and Mrs. Gillespie informed us that its organization is being perfected and that it promises to be the best health education presentation for the public in the history of our State. We approve the proposal and recommend that the Board of Trustees work with the officials of the Mississippi Health Expo I to bring it into being and furnish to it the sponsorship of our association. We recommend approval of the project by the House of Delegates.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT J OF THE BOARD OF TRUSTEES

Committee on Long-Range Planning. The Council on Budget and Finance recommended to the Board of Trustees that provision be made for a Committee on Long-Range Planning. It is to consist of five members appointed for staggered terms of five years each, and selection is to be made from among the most able and experienced members available for service.

The purpose of the committee is to assess the rapid and sometimes drastic developments in socioeconomics, health care delivery, the programs of the association, services to the membership, and other aspects of delivering patient care. From time to time, the Board would give the committee specific charges and requests.

The Board of Trustees is empowered to appoint members to *ad hoc* committees for terms of one year. To provide a committee with members appointed for five year terms, it is necessary to have a constitutional committee of the Board rather than an *ad hoc* committee. It is necessary to amend the By-Laws to provide such a committee.

Amendment. The Board recommends that the following section be added to Chapter X of the By-Laws.

"Section 6. Committee on Long-Range Planning. The Committee on Long-Range Planning shall consist of five members appointed for terms of five years each and so arranged to provide for appointment of one member annually. This committee shall receive charges from the Board of Trustees and shall assess developments and requirements in fields of association activity, making recommendations for courses of action to achieve maximum possible effectiveness in all fields of association activity."

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

The Board of Trustees has proposed creation of a five-member Committee on Long-Range Planning, the members to be appointed for terms of five years and so arranged that one member is appointed annually. The committee will report to the Board of Trustees, and we approve the following addition to Chapter X of the By-Laws:

"Section 6. Committee on Long-Range Planning. The Committee on Long-Range Planning shall consist of five members appointed for terms of five years each and so arranged to provide for appointment of one member annually. This committee shall receive charges from the Board of Trustees and shall assess developments and requirements in fields of association activity, making recommendations for courses of action to achieve maximum possible effectiveness in all fields of association activity."

The report of the council, acting as a reference committee, was adopted.

REPORT OF THE SECRETARY-TREASURER

Dr. Raymond S. Martin, Jr.: Duties and Responsibilities. As an elected general officer of the association, your Secretary-Treasurer is charged with such duties as ordinarily devolve upon the secretary of a corporation by law, custom, and usage. Additionally, he is the constitutional designee to serve as chairman of the Council on Scientific Assembly and member *ex officio* of all councils and committees.

Membership. There was a continuing modest growth in our membership during 1970 over preceding years. The total as of Dec. 31, 1970, was:

1,349 paid Active members
68 Emeritus members
34 members exempt from dues other
69 Emeritus members
than Emeritus

This is a total of 1,451 for 1970, and it represents our best recorded membership. Our new unified billing system which also generates permanent records for our component medical societies has greatly assisted in dues collection for 1971. As of April 15, 1971, our current year's membership was:

1,253 paid Active members
43 members exempt from dues other
than Emeritus

This is a total of 1,365 for 1971. Additional payments of dues have been made since preparation of these data, and there are fewer than 75 unpaid members who were in good standing in 1970.

MISSISSIPPI STATE MEDICAL ASSOCIATION
CONDENSED STATEMENT OF
FINANCIAL CONDITION
DECEMBER 31, 1970

ASSETS

Current Assets		
General Fund		
Cash on deposit	$160,066	$
Accounts receivable, JOURNAL advertisers	3,822	
Accounts receivable, CHAMPUS	8,554	
Other receivables	3,596	
Prepaid expenses	283	176,321
Fixed Assets		
Building and equipment, less depreciation	189,894	
Land	14,242	204,136
Other Assets		
Deferred CHAMPUS expenses	3,597	
Refundable deposits	25	3,622
Total book assets		$384,079

LIABILITIES AND NET WORTH

Current Liabilities		
Accrued expenses	$ 4,104	$
AMA dues in transit	87,890	
AMA dues pending	115	
Current mortgage	6,940	
Accrued taxes	7,056	
Accounts payable, CHAMPUS	3,147	
Society dues in transit	1,296	
MPAC & AMPAC dues in transit	10,020	$120,568
Long Term Liabilities		
Mortgage	$ 75,650	
Deferred income	83,050	$158,700
Net Worth		104,811
Total liabilities and net worth		$348,079

Fiscal Reporting. In accordance with usual practice, your Secretary-Treasurer submits a condensed statement of your association's financial condition as reported by the Board of Trustees' independent certified public accountant. The Council on Budget and Finance prepared the budget for 1971 which was approved by the Board of Trustees, and a copy is attached to this report. This is exclusive of funds which will be expended by the association in payment of claims

under the Civilian Health and Medical Program of the Uniformed Services. Such expenditures are reimbursed to the association by the Department of Defense.

Constitutional Duties. Your Secretary-Treasurer, as an *ex officio* member of councils and committees, meets with various official bodies of the association and sits with the Board of Trustees as a general officer. Activities related to service as chairman of the Council on Scientific Assembly are reported separately.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee thanks Dr. Raymond F. Martin, Jr., the Secretary-Treasurer of the association, for his report and we are pleased and encouraged by the success of the new central dues billing system which he has reported to us. We thank him for his work also as chairman of the Council on Scientific Assembly and we approve his report and recommend its adoption by the House of Delegates.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON BUDGET AND FINANCE

Report of the Secretary-Treasurer. We have considered the fiscal portion of the report of our Secretary-Treasurer, Dr. Raymond S. Martin of Jackson, and we have examined the operation of the association with respect to all fiscal activities including the report of audit by our independent certified public accountant. The findings are to the satisfaction of your council. In 1970, we implemented a new budget preparation and approval policy which permits your council to meet twice annually with the Board of Trustees. We prepared the budget in December for the fiscal year 1971 as required by the By-Laws. We met again with the Board in the spring of 1971 to review performance of the budget prior to this annual session. We have determined that all accounts, receipts, and disbursements are regular, proper, and authorized.

Association Fiscal Management. At the 102nd Annual Session in 1970, the House of Delegates amended the By-Laws to provide for an increase of five members from the present three members of your Council on Budget and Finance. Under this action, elections for the additional seats are to be made at the present annual session. Your council is convinced of the merit and wisdom of this decision, and we thank the House of Delegates for making this provision for us.

Association Budget. We have considered the 1971 budget for operation of your association with conference with the Board of Trustees as previously reported. Each item on the budget has been carefully and separately evaluated as to necessity and adequacy. We recommend a total budget of $248,700.00 for general operation of all activities and departments of the association, including production of your JOURNAL. The overall budget is exclusive of professional fees and other payments to be made under the CHAMPUS program which are reimbursed to the association by the Department of Defense. For 1971, we estimate that this amount will be $2.5 million. We recommend adoption of the budget as being a realistic minimum for the continued effective operation of your association.

Insurance and Safeguards. We have examined a survey of insurance owned by the association on its properties and against certain liabilities which conceivably could be incurred, and we find it adequate. We have recently authorized installation of a security alarm system in the headquarters building as a protection against burglary and unlawful entry. We have examined procedures used to safeguard the handling of incoming funds as well as disbursement procedures which meet with the approval of our independent certified public accountants. We are pleased with the successful operation of the new centralized membership billing system which generates records for component medical societies and provides for systematic transmittal of dues for AMA, AMPAC, and contributions for AMA-ERF. Effective with the 1972 association year, the association will assist our Woman's Auxiliary by including in the billing statement dues for the physician's wife. We will continue to furnish tax records in the statement for dues so paid.

Personal Expression. Your council chairman retires from membership on this important body of our association at the conclusion of this annual session, having served the constitutional maximum of three consecutive terms. In requesting the indulgence of this House of Delegates for this personal expression, your chairman thanks Dr. George D. Purvis of Jackson and Dr. Daniel L. Hollis of Biloxi, his faithful and dedicated colleagues for their good work. In nine years, there has not been a single absence from a meeting by any member of the council, and we believe that this is a record seldom achieved by any body of the association. We also thank the Board of Trustees, our executive staff, and our independent certified public accountants who worked with us. I am deeply grateful for these

supportive services because the work of this council has become increasingly important as the association continues to grow and extend its activities into new and varied fields of service in behalf of the medical profession.

The report of the council was adopted.

REPORT OF THE EXECUTIVE SECRETARY

Mr. Rowland B. Kennedy: Scope of Report. Your Executive Secretary, under the By-Laws, reports to the Board of Trustees, and as such has submitted about 75 written and oral reports during the 1970-71 association year. The present report deliberately omits repetition of this detailed reporting and is limited to highlights and your headquarters executive staff.

Staff. In 1970, I reported an urgent need for staff expansion both as to then-ongoing programs and for the expanded program of services approved by the House of Delegates, especially in the areas of medically-sponsored peer review and legislation. A third executive was authorized and appointed as was an additional administrative position. Without this additional staff, we could not have furnished necessary support for your substantially expanded programs of service and activity. This year, our third executive resigned to accept employment more attractive financially, and I recommended deferment of replacing him until after the present annual session. This will assure appointment of a suitably qualified individual with special reference to the decision on further activities which the House might authorize and afford us a better opportunity for orientation and training when demands upon us are less intense than they are during the legislative sessions.

Organization and Program. The Board of Trustees approved a further reorganization of the executive staff into three divisions after appointment of the third executive. These are Scientific Activities (with the JOURNAL and the Scientific Assembly), Management Services (with CHAMPUS administration, membership and member service activities, and data processing), and Medical Services (with activities of the council and its committees, legislation, and peer review).

To assure necessary staff services, we must soon return to personnel levels previously authorized and augment to meet growing needs. Established programs continue to grow, and CHAMPUS is the best example. We experienced a growth in claims volume of 25 per cent in 1970 over 1969. The extensive peer review program and expanded legislative activities added about 20 per cent to the work volume.

I am grateful for our experienced, well-trained group in your service, and in a sincere effort to maintain a level of quality which you deserve, I urge you to meet the challenge of competitive compensation and employment benefits characteristic of the greater Jackson area.

It is especially gratifying to announce that following the 1970 annual session, the Board of Trustees approved my recommendation to promote H. Cody Harrell to the position of Assistant Executive Secretary. As he concludes his second year with the association, he is deserving of our commendation for his work in internal management, development of an extensive corporate cost accounting system, and greatly improved data processing services.

Headquarters Building. As of May 1, 1971, the amortization of the original building, occupied during your Centennial Annual Session in 1956, was completed with the final payment of the original financing. The second stage, our 1960 west wing addition, was paid in cash, as you will recall. The major 1970 addition is being amortized under a 10-year schedule begun last year under a favorable year-to-year, simple interest circumstance arranged by the Council on Budget and Finance and the Board of Trustees. You have in your Jackson headquarters property a priceless real asset which serves you well.

Personal Expression. As I enter my third decade of service to your association and the profession, I am acutely aware of the massive challenges confronting the private delivery system, and I am enthusiastic rather than discouraged or fearful over your forward thinking, determined proposals to meet these challenges. This is a time for leadership and courage which are characteristic of physicians. I hope that we of the staff may worthily contribute to your exercise of these qualities of your profession.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the report of the Executive Secretary noting particularly his remarks on the staff and headquarters building. We express our appreciation to all members of the executive staff and we express further appreciation to the House of Delegates and Board of Trustees for providing a good work environment and the tools necessary for our staff to carry on the administrative services required by our association. We approve the report of the Executive Secretary and recommend adoption by the House of Delegates.

The report of the reference committee was adopted.

REPORT OF THE COMMITTEE ON AMA-ERF

Dr. Raymond F. Grenfell: Organization and Duties. Your Committee on the American Medical Education and Research Foundation is an *ad hoc* body of the House of Delegates. Our duty is to encourage members of the association and Woman's Auxiliary to support AMA-ERF with voluntary, tax-deductible contributions. Every dollar received goes to medical education or research, and the donor may earmark his gift for a particular institution of his choosing. No administrative expense or cost of fund solicitation is taken from gifts: The AMA and state medical associations pay the modest costs of conducting the program.

1970 Program. Last year, our total gift to the University of Mississippi School of Medicine and Medical Center was $11,102.40, representing $8,615.94 from physicians and Auxiliary members in earmarked funds and $2,486.46 in undesignated foundation funds distribution. The latter are unearmarked gifts which are equally distributed among all accredited four-year medical schools by AMA-ERF.

1971 Program. The current campaign was initiated in the fall of 1970 with mailings from the medical school and association. The University of Mississippi Medical Alumni Association fulfills a key leadership role in the campaign, and your committee works in concert with the alumni association. Additionally, appeals are made through the JOURNAL.

Our total gift in April 1971 was $10,820.30, a decrease from 1970. Nationally, there was a decrease of about 20 to 30 per cent among the states. Mississippi's per capita gift level remains high in comparison with other states.

With the initiation of the new unified billing system, an opportunity was given members to include AMA-ERF gifts with dues payments. It should be borne in mind that the billing statements were mailed after the solicitation campaign was conducted, but we received $1,180.00 with dues payments, and each gift was acknowledged with a personal letter of appreciation. Most of these gifts are not included in the total reported, thereby increasing our contribution.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your reference committee considered the annual report of our Committee on AMA-ERF and we commend Dr. Raymond F. Grenfell, the chairman, and his colleagues for their work in behalf of the foundation and medical education. We note that provision has been made in the new central billing system for making AMA-ERF contributions, and we strongly urge that each member of the association contribute to the medical educational institutions of his choice through AMA-ERF by earmarking or designating his gift.

The report of the reference committee was adopted.

AUXILIARY OFFICERS

The Speaker presented Mesdames Curtis W. Caine of Jackson, 1970-71 President of the Woman's Auxiliary to the Mississippi State Medical Association, and T. E. Ross, III, of Hattiesburg, 1971-72 President, who addressed the House of Delegates.

1971 MSMA-ROBINS AWARD

President Brumby presented the 1971 Mississippi State Medical Association-Robins Award to Dr. Walter H. Rose of Indianola for outstanding community service by a physician. Mr. Willard Duvall of New Orleans, district manager for A. H. Robins Co., assisted Dr. Brumby in the presentation.

SCIENTIFIC EXHIBIT AWARD

Dr. Raymond S. Martin, Jr., of Jackson, chairman of the Council of Scientific Assembly, presented the Aesculapius Award, a cash honorarium of $200 to Drs. Ottis G. Ball and Fred A. Lewis of Jackson for the best scientific exhibit by a member or members of the association, "Abdominal Angiography."

The second award in this category, a cash honorarium of $100, was presented to Drs. B. T. Hickman, W. M. Flowers, and J. O. Morris of Jackson for their exhibit "Modern Radiotherapy: A Vital Aid to Cancer Management."

The Mississippi State Medical Association Scientific Achievement Award, a bronze medallion, given for the best scientific exhibit by nonmember, out-of-state guests, was awarded to Drs. Hector Howard, H. Edward Garrett, and J. T. Davis, Jr. of Memphis for their exhibit "Ventricular Resection Following Myocardial Infarction." Dr. J. T. Davis of Corinth accepted the award on behalf of his son and Drs. Howard and Garrett.

RECOMMENDATION TO THE HOUSE OF DELEGATES

Noting the decline in participation in the Technical Exhibits by ethical pharmaceutical manufacturing organizations, Dr. J. T. Davis of Corinth recommended that each physician, when re-

ceiving professional service representatives, invite the company represented to exhibit at the annual session of the association.

RESOLUTION NO. 1, IN MEMORIAM

Dr. Raymond S. Martin, Jr.: WHEREAS, There are absent from among our numbers 28 members who have been called by Divine Province since the 102nd Annual Session; and

WHEREAS, Although we are grieved upon the passing of these beloved colleagues and friends, we are inspired by their lives of service and professional attainment; and

WHEREAS, This expression of our grief, deep affection, and respect should be recorded permanently among official records of the Mississippi State Medical Association, now therefore, be it

Resolved, That this House of Delegates does mourn the passing of the following esteemed colleagues:

Herbert L. Arnold, Tuscaloosa, Ala., December 20, 1970
Fletcher C. Boren, Mantachie, March 2, 1971
Frank L. Brantley, Madden, January 31, 1971
Samuel L. Brister, Jr., Greenwood, February 25, 1971
Louis E. Cowsert, Ocean Springs, May 3, 1970
James T. Doster, Columbus, December 23, 1970
John J. Eberhart, Ocean Springs, October 22, 1970
Roy G. Grant, Holly Springs, July 17, 1970
Zebulan B. Graves, Hattiesburg, May 18, 1970
Robert G. Hand, Philadelphia, March 21, 1971
Charles C. Hightower, Sr., Hattiesburg, October 28, 1970
Norris C. Knight, Sr., Jackson, March 31, 1971
Byron A. Mayo, Drew, April 1, 1971
Albert J. McIlwain, Jackson, February 15, 1971
John S. McIntosh, Jackson, March 12, 1971
Wallace C. Moore, Jr., Rosedale, May 22, 1970
Onnie P. Myers, Jackson, October 23, 1970
Charles W. Patterson, Rosedale, December 21, 1970
Thomas Purser, Jr., Summit, January 24, 1971
Tobe M. Riddell, Shaw, February 27, 1971
W. L. Stallworth, Columbus, October 2, 1970
Richard A. Street, Jr., Vicksburg, November 23, 1970
William S. Sweat, Jackson, April 20, 1970
A. L. Thaggard, Madden, February 7, 1971
Sherrod R. Towns, Union Church, August 10, 1970
E. A. Trudeau, Biloxi, May 1, 1970
George E. Twente, Jackson, January 5, 1971
J. F. Van Pelt, Gulfport, December 1, 1970

ACTION OF THE HOUSE OF DELEGATES

Without objection, Resolution No. 1 was acted upon without referral and adopted by the House of Delegates with all present standing in silent tribute.

RESOLUTION NO. 2, STATE MEDICAL EXAMINER

Dr. Joel L. Alvis: WHEREAS, Many states have established a medical examiner system to assist in securing the administration of justice under law and the rights of the public, and

WHEREAS, The benefits of such a system are well-established and would be applicable to Mississippi, and

WHEREAS, There are interest in and means for establishing a medical examiner system in Mississippi, now, therefore, be it

Resolved, That the Mississippi State Medical Association does endorse and support the establishing of an office of a state medical examiner for Mississippi to include any studies or pilot or demonstration projects and enactment of suitable and necessary legislation for this purpose, and be it further

Resolved, That the office of the state medical examiner be accorded independent status in law to preserve the exercise of professional integrity and the integrity of the examiner's statutory function and further be accorded statutory authority to initiate such other investigations within the purview of his office which he deems appropriate in addition to those investigations which are specified by law.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your reference committee had the benefit of informed and enlightening discussion on Resolution No. 2 which proposes establishing an office of the State Medical Examiner. We are especially grateful to the officers and members of the Mississippi Association of Pathologists who have sponsored this resolution.

Your reference committee approves the proposal as set out in the resolution and offers the following substitute resolution with a recommendation for adoption by the House of Delegates:

WHEREAS, Many states have established a medical examiner system to assist in securing the administration of justice under law and the rights of the public, and

WHEREAS, The benefits of such a system are well-established and would be applicable to Mississippi, and

WHEREAS, There are interest in and means for establishing a medical examiner system in Mississippi, now, therefore, be it

Resolved, That the Mississippi State Medical Association does endorse and support the establishing of an office of State Medical Examiner who shall be a qualified forensic pathologist and this endorsement includes any studies or pilot or demonstration projects and the enactment of suitable and necessary legislation for this purpose, and be it further

Resolved, That the office of State Medical Examiner be incorporated into the faculty structure of the University of Mississippi School of Medicine where this qualified forensic pathologist may engage in teaching as well as in performance of the duties of State Medical Examiner, and be it further

Resolved, That consideration be given to the possibility of establishing a Department of Forensic Medicine in this connection within the University of Mississippi School of Medicine.

The report and recommendation of the reference committee were discussed by Drs. Charles J. Cox of Bay St. Louis, John R. Lovelace of Batesville, John B. Howell, Jr., of Canton, and William H. Preston, Jr., of Booneville (who stepped aside as chairman of the reference committee to speak from the floor as a delegate).

The report of the reference committee was adopted.

RESOLUTION NO. 3, LICENSURE OF CHILD CARE CENTERS

Dr. Wilfred Q. Cole, Jr.: WHEREAS, All but two state jurisdictions have provided for licensure of child care centers and day care facilities in the interest of the health and safety of children, and

WHEREAS, This issue has been before the Mississippi Legislature during regular session for more than 10 years but has, for want of understanding and unified support, been unsuccessful, and

WHEREAS, Suitable licensure legislation establishing mandatory minimums for environmental health and safety for child care in Mississippi is in paramount interest to the medical profession and should be considered a major legislative goal in the public interest, now, therefore, be it

Resolved, That the Mississippi State Medical Association does endorse and commit its support to prompt enactment of legislation providing for mandatory licensure of child care centers and day care facilities in Mississippi both as to environmental health and safety, and be it further

Resolved, That the Board of Trustees of the Mississippi State Medical Association be requested to cause the drafting, introduction, and support of suitable bills, either in concert with others who seek this goal or under association sponsorship, for consideration by the 1972 Regular Session of the Mississippi Legislature.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your reference committee approves Resolution No. 3, Licensure of Child Care Centers, and requests that the Board of Trustees refer this to the Council on Legislation for early introduction in the 1972 regular session of the Legislature.

The report of the reference committee was adopted.

RESOLUTION NO. 4, REPEAL OF MANDATORY AMA DUES

Dr. Joel L. Alvis: WHEREAS, The American Medical Association first levied dues upon members in 1951, and

WHEREAS, Thirteen state medical associations, including the Missouri State Medical Association, acted to amend state by-laws to make AMA membership mandatory for state association members, whether paid or exempt from dues, and

WHEREAS, Many physicians conscientiously believe that they should be free to make a decision on AMA membership as individuals without coercion, compulsion, or penalty against their component society and state association membership, and

WHEREAS, Only nine state medical associations now retain the constitutional requirement for mandatory AMA membership, now, therefore, be it

Resolved, That Section 5, Chapter I, of the By-Laws be repealed and the following new section substituted therefor:

"Section 5. American Medical Association. Members of this Association, desiring to be members of the American Medical Association, may pay the dues or apply, when eligible, for a legal exemption from the dues of the American Medical Association. Those desiring to do so may pay the dues to the Executive Secretary whose duty it shall be to transmit them to the American Medical Association and to obtain proper credits and receipts therefor."

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Resolution No. 4 seeks amendment of Section 5, Chapter I, of the By-Laws to provide for voluntary participation by our members in the American Medical Association. The premise of the resolution is that many physicians conscientiously believe that they should be free to make a decision on AMA membership as individuals without co-

ercion, compulsion, or penalty against their component society and state medical association membership. Your council approves the resolution which was thoroughly discussed at our hearing and recommends the following amendment to the By-Laws:

Section 5, Chapter I, of the By-Laws is repealed, and the following new section is substituted therefor. "Section 5. American Medical Association. Members of this association desiring to be members of the American Medical Association may pay the dues or apply when eligible, for legal exemption from the dues of the American Medical Association. Those desiring to do so may pay their dues to the Executive Secretary whose duty shall be to transmit them to the American Medical Association and to obtain proper credits and receipts therefor."

In recommending this amendment to the By-Laws, your Council on Constitution and By-Laws respectfully urges every member of the Mississippi State Medical Association to weigh conscientiously the merit and value of AMA membership, and we encourage continued universal participation in our parent medical body by all eligible physicians in Mississippi.

The chairman moved adoption of the report.

In discussion, Dr. H. C. Ricks, Sr., of Jackson asked a procedural question as to the manner of payment of AMA dues, and it was stated that payment is now made to the Executive Secretary under the central billing system but that such billings are made only with prior permission of component medical societies.

Dr. Bedford F. Floyd of Gulfport asked what the objections to AMA dues are and why any change should be made. Dr. L. H. Brandon of Starkville requested information as to the position of the AMA Delegates on the question, and Dr. G. Swink Hicks of Natchez, chairman of the delegation, responded that he intended to maintain his AMA membership and hoped that all eligible physicians would see fit to do so.

There being no further discussion, the Speaker put the question, and the report of the council, acting as a reference committee, was adopted.

RESOLUTION NO. 5, COMBINATION INGREDIENT DRUG PRODUCTS

Dr. J. Dan Mitchell: WHEREAS, The Food and Drug Administration has issued regulations prohibiting marketing and use of drug products with more than one ingredient unless it is demonstrated to the satisfaction of FDA that each added ingredient would enhance the effectiveness of the product by increasing potency or prolonging its effect and that the safety of the product is thereby enhanced by decreasing or reducing severity of adverse effect or preventing possible misuse or abuse, and

WHEREAS, Implementation of this policy constitutes an incursion in and usurpation of medical practice by the Food and Drug Administration, now, therefore, be it

Resolved, That the Mississippi State Medical Association does oppose the policy of the Food and Drug Administration to remove from the physician's therapeutic armamentarium combination ingredient drug products, thereby denying him and his patient the convenience and economy of many proven products and which policy can and will result in government usurpation of medical practice, a needless increase in the cost of drugs to the patient, and a waste of research and clinical manpower, facilities, and expense in satisfying the restrictive requirements.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Resolution No. 5 which expresses opposition to the recently announced policy of the Food and Drug Administration to remove certain combination ingredient drug products from the ethical pharmaceutical market.

We approve the resolution and recommend adoption of the following substitute resolving clause:

"*Resolved,* That the Mississippi State Medical Association does oppose the policy of the Food and Drug Administration to remove from the physician's therapeutic armamentarium combination drug ingredient products, thereby denying him and his patient the convenience and economy of many proven products. We believe that this policy can and will result in government usurpation of medical practice, a needless increase in the cost of drugs to the patient, and a waste of research and clinical manpower, facilities, and expense in satisfying these restrictive requirements."

The report of the reference committee was adopted.

RESOLUTION NO. 6, TRAINING PROGRAMS IN FAMILY PRACTICE

Messrs. William J. Gibson, Jr., and Paul B. Welch: WHEREAS, The 20th medical specialty has been formalized with creation of the American Board of Family Practice, and

WHEREAS, The American Medical Association and the American Academy of General Practice worked in diligent and productive concert to establish this specialty board over a period of three years with full approval by the AMA House of

Delegates, the AAGP Congress of Delegates, and the Advisory Board to the Medical Specialties, and

WHEREAS, AMA and AAGP have urged our medical schools to establish Departments of Family Practice as co-equal academic and clinical departments with existing departments, adapting training programs to family practice core curricula, with appropriate residencies in affiliated hospitals, and

WHEREAS, Many medical students at the University of Mississippi School of Medicine desire to train for family practice and to enter into practice in this needed specialty, now, therefore, be it

Resolved, That the Mississippi State Medical Association does endorse and approve creation of a full academic and clinical Department of Family Practice at the University of Mississippi School of Medicine and Medical Center as well as appropriate residencies in family practice for training board-eligible physicians in this specialty, and be it further

Resolved, That the association does pledge its support to the University of Mississippi School of Medicine and Medical Center in this necessary and worthy program.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

This resolution was introduced by our student delegates from the University Medical Society and seeks association endorsement for establishing a Department of Family Practice at the University of Mississippi School of Medicine. We strongly urge that this department be established without delay and that residency programs for training physicians eligible for certification in this new specialty also be established.

We are aware of the interest of the Legislature in this program and none need be reminded of the urgent and desperate need for family practice specialists. We request that the Board of Trustees, the Council on Medical Education, and the Council on Legislation coordinate their efforts in supporting this needed and vital development, and we ask that the Board of Trustees supervise and oversee the implementation of this resolution giving full association support to the proposal. We recommend adoption of the resolution and thank the student delegates for their thoughtful discussion before our committee.

The report of the reference committee was adopted.

RESOLUTION NO. 7, EMERGENCY PERSONNEL ACT OF 1970

Messrs. William J. Gibson, Jr., and Paul B. Welch: WHEREAS, There are many areas of Mississippi that are presently experiencing a physician shortage, and

WHEREAS, On Dec. 31, 1970, the President signed into law, after almost unanimous approval by both Senate and House, Public Law 91-623, which provides for the U. S. Public Health Service to staff areas designated by state and local health agencies and medical societies as areas in need of emergency health personnel, and

WHEREAS, The new Emergency Health Personnel Act allows for participation as an alternative to armed services, therefore, be it

Resolved, That the Mississippi State Medical Association make an all out effort to publicize the significance and ramification of this new law, and be it further

Resolved, That this House of Delegates encourage action of the public and private health agencies in Mississippi to make rapid efforts to determine areas at both the state and county levels in need of emergency health personnel, and be it further

Resolved, That the Mississippi State Medical Association Board of Trustees be requested to implement this resolution and to assure that the state derive maximum possible benefit from the Emergency Personnel Act of 1970.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your reference committee was informed that the Board of Trustees has already invoked the Emergency Health Personnel Act of 1970 in declaring a health personnel shortage in Alcorn County. We approve the resolution and request that wide publicity among public and private health agencies and organizations be given this in Mississippi. We recommend adoption of the resolution.

The report of the reference committee was adopted.

RESOLUTION NO. 8, PROTECTION OF PUBLIC HEALTH PHYSICIANS

Dr. Hugh B. Cottrell: WHEREAS, New York state law provides that a public health physician shall be indemnified and held harmless for judgments entered after a verdict and award of malpractice when he is in pursuance of his duties, and

WHEREAS, A recent court decision in New York requires that the state defend such suits as well as indemnify and hold harmless the defendant public health physician, and

WHEREAS, A public health physician should receive the same protection of his state as is accorded other public agencies in legal defense, indemnification, and holding harmless, now, therefore, be it

Resolved, That the Mississippi State Medical Association sponsor legislation for the State of Mississippi to defend, indemnify, and hold harmless a public health physician who is sued for malpractice in a cause arising out of the performance of his lawful duties.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

This resolution asks that the State Medical Association seek protection from professional liability litigation for public health physicians on the logical premise that these physicians are entitled to the same protection as would be accorded other state agencies and employees. The resolution asks that the state defend, indemnify and hold harmless any public health physician sued for malpractice arising out of performance of his duties under the law. We recommend adoption of the resolution.

The chairman of the reference committee moved adoption of the report.

Dr. Mal S. Riddell, Jr., of Winona moved to amend the report by deleting the last sentence and substituting therefor "In the interest of protecting the patient, a physician should not be held harmless for an act or acts that may in fact be malpractice. Rather than recommending protection from liability litigation, we request that the State Board of Health be authorized by the Legislature to purchase adequate malpractice insurance to protect the public health physician." The amendment was seconded by Dr. H. C. Ricks, Sr., of Jackson.

There being no discussion, the Speaker put the amendment which was adopted. The report of the reference committee was adopted as amended.

RESOLUTION NO. 9, MEDICINE AND RELIGION PROGRAM

Dr. Raymond S. Martin, Jr.: WHEREAS, The House of Delegates in 1957 adopted a policy for including topics in the scientific assembly from disciplines other than medicine to enhance the healing principle and care of the whole man, and

WHEREAS, The Council on Scientific Assembly has supported and implemented this policy with various symposia and special presentations, and

WHEREAS, The program of the Committee on Medicine and Religion most emphatically includes physician-clergyman activities within the local medical community, now, therefore, be it

Resolved, That the House of Delegates of the Mississippi State Medical Association does urge that each component medical society establish a Committee on Medicine and Religion which will be, in turn, supported and assisted by the State Medical Association's Committee on Medicine and Religion, and be it further

Resolved, That the Board of Trustees be requested to oversee and assist this program through its Committee on Medicine and Religion.

ACTION OF THE HOUSE OF DELEGATES

The resolution, introduced on May 6, 1971, under the rules pertaining to the scientific work of the association, was acted upon without referral and adopted by the House of Delegates.

RESOLUTION NO. 10, IN MEMORIAM

Dr. Raymond S. Martin, Jr.: WHEREAS, On May 3, this House of Delegates adopted Resolution No. 1, Subject: In Memoriam, recording the passing of 28 members of our association since the 102nd Annual Session; and

WHEREAS, One such member was inadvertently omitted; now therefore, be it

Resolved, That this House of Delegates does mourn the passing of Dr. George M. Wilson of Gulfport, Mississippi, in January 1971 and does make this expression of grief, deep affection, and respect to his family, noting that Dr. Wilson once served as a member of the Board of Trustees and contributed valuably and substantially to the work of our association.

ACTION OF THE HOUSE OF DELEGATES

Without objection, Resolution No. 10 was acted upon without referral and adopted by the House of Delegates with all present standing in silent tribute.

RESOLUTION NO. 15 (1970)

The House of Delegates took from the table Resolution No. 15, 102nd Annual Session, 1970, subject: Parliamentary Standard of the Association, and referred it to the Council on Constitution and By-Laws.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

At the 102nd Annual Session on the final day, Resolution No. 15, Subject: Conduct of the House of Delegates, was introduced by Dr. Howard A. Nelson of Greenwood. The resolution proposes that Section 4, Chapter V, By-Laws of the association be amended to delete *Robert's Rules of Order, Newly Revised,* as the parliamentary standard of the House of Delegates and substitute therefor *Sturgis Standard Code of Parliamentary Procedure.* We appreciate assistance in our dis-

cussions by Dr. Walter C. Bornemier who is a former speaker of the AMA House of Delegates. We believe that the *Sturgis Code* is clearer, and it is shorter than *Robert's Rules of Order, Newly Revised*. In addition, the *Sturgis Code* provides parliamentary procedure for reference committees patterned after those of the American Medical Association and most Houses of Delegates of state medical associations. Your council approves Resolution No. 15 (1970) and recommends its adoption.

The report of the council, acting as a reference committee, was adopted.

OFFICIAL ATTENDANCE

The Executive Secretary announced the official attendance as being 904 to include 420 members, 86 physician-guests, 20 residents, five medical students, 73 nonphysician guests, 75 exhibitors, 215 Auxiliary members, and 10 staff.

REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

Conduct of Business. Your reference committee commends the Speaker and Speaker *pro tem* for the outstanding manner in which they have conducted business before this House of Delegates. We believe that all members will wish to associate themselves in this expression of appreciation and we add to that our good wishes for the speedy recovery of our unavoidably absent Speaker, Dr. William E. Lotterhos of Jackson.

Resolution. The reference committee desires to offer the following resolution for consideration by the House of Delegates:

WHEREAS, The 103rd Annual Session of the Mississippi State Medical Association has been conducted at Biloxi, Mississippi during the period May 3-6, 1971, and

WHEREAS, The annual session has been most profitable and enjoyable for all who have been in attendance, now, therefore, be it

Resolved, That expressions of deep appreciation are made to the officers, Trustees and Council on Scientific Assembly for the stimulating and worthwhile scientific programs; to the management of the Sheraton-Biloxi for splendid services, to other participating hotels and motels, to the press, radio and television for coverage of our activities, to the gracious ladies of the Auxiliary who always contribute so substantially to our meetings, to the technical exhibitors and their professional service representatives, to our scientific exhibitors who have contributed to our learning and instruction, to our distinguished guests, particularly Dr. Walter C. Bornemeier of Chicago, President of the American Medical Association, and to all who have shared in the responsibilities of planning, organizing and conducting this great annual session.

Your reference committee recommends adoption of this resolution.

The report of the reference committee was adopted.

REPORT OF THE ELECTION OF OFFICERS

President-elect: Charles R. Jenkins, Laurel.

Vice Presidents: Benton M. Hilbun, Tupelo; John G. Atwood, Meridian; and O. D. Dabbs, Gulfport.

Associate Editor: Thomas W. Wesson, Tupelo (1973).

Delegate to AMA: G. Swink Hicks, Natchez (1973).

Alternate Delegate to AMA: Joseph B. Rogers, Oxford (1973).

Board of Trustees: Paul B. Brumby, Lexington, District 4; James L. Royals, Jackson, District 5; and Guy T. Vise, Meridian, District 6 (1974).

Council on Budget and Finance: James O. Gilmore, Oxford (1974); Walter H. Rose, Indianola (1973); and Jack A. Atkinson, Brookhaven (1972).

Council on Constitution and By-Laws: Raymond S. Martin, Jr., Jackson (1974).

Judicial Council: John G. Egger, Drew, District 1; John R. Lovelace, Batesville, District 2; and Frank M. Davis, Corinth, District 3 (1974).

Council on Legislation: Walter H. Rose, Indianola, District 1; T. L. Ketchum, Ripley, District 2; and William H. Preston, Jr., Booneville, District 3 (1974).

Council on Medical Education: Carl G. Evers, Jackson (1974).

Council on Medical Service: Edward Pennington, Ackerman, District 4; Tom H. Mitchell, Vicksburg, District 5; and William M. Gillespie, Meridian, District 6 (1974).

Mississippi State Board of Health, terms Jan. 1, 1972-Dec. 31, 1977:

Public Health District 6: Joseph G. McKinnon, Hattiesburg; William E. Weems, Laurel; and Bedford F. Floyd, Gulfport.

Public Health District 7: G. Swink Hicks, Natchez; W. Moncure Dabney, Crystal Springs; and R. J. Field, Jr., Centreville.

Public Health District 8: Wilfred Q. Cole, Jr., Jackson; E. L. Whitfield, Florence; and H. C. Ricks, Sr., Jackson.

CONSTITUTION AND BY-LAWS

At the close of business, no amendments to the Constitution or By-Laws were pending.

CLOSING CEREMONIES

There being no further business, the Speaker returned the gavel to President Brumby. The Oath of Office was administered to Dr. Arthur E. Brown, the President-elect, by Dr. Mal S. Riddell, Jr., Chairman of the Board of Trustees, after which Dr. Brown addressed the House of Delegates.

Dr. James Grant Thompson of Jackson presented the Thompson Memorial Past President's Pin to Dr. Brumby.

The House of Delegates was adjourned *sine die* at 5:00 o'clock in the afternoon, May 6, 1971.

VIDEO VERACITY

A new television soap opera has been announced for the fall season. The story revolves around the problems, aspirations, and strivings of an unfaithful wife, a drug addict, a student anarchist intent upon blowing up the university, a child molester, a corrupt public official, and a criminal abortionist.

The program is entitled "Just Plain Folks."

HEALTH SCIENCES LIBRARY

Miami Presents Course in Otolaryngology

A postgraduate course in otolaryngology for the family physician will be presented by the department of otolaryngology at the University of Miami School of Medicine Oct. 8-9, 1971 at the Sheraton Four Ambassadors Hotel in Miami.

The postgraduate education course will be acceptable for nine hours of American Academy of Family Practice credit.

For further information, write: Dr. F. W. Pullen, II, M.D., Neuro-Otologic Laboratory, School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

AAP Annual Meeting Set for Chicago

The American Academy of Pediatrics will hold its 40th annual meeting at the Palmer House Hotel, Chicago, Ill., Oct. 16-21.

The meeting will feature a versatile program including: seven symposiums during the general sessions on teen-age pregnancy; behavior modification by drugs; divorce: its effects on children; immunizations—progress and problems; environmental hazards; mists, aerosals and oxygen; and exciting new developments in pediatrics.

Approximately 133 papers on all facets of pediatrics will be presented during meetings of the Sections on Allergy, Anesthesiology, Cardiology, Child Development, Community Pediatrics, Diseases of the Chest, Military Pediatrics, Pediatric Pharmacology, and Surgery plus the Committee on Urology.

Seventeen round tables covering such subjects as family therapy, seizures, allergy, failure to thrive, cardiology, visual diagnosis: neurology, and renal disease and 18 seminars covering such areas of pediatrics as cardiology for pediatricians, newborn and premature, allergy, antibiotics, immunology, neurology, psychiatry, pediatric orthopedics, endocrinology, dermatology, fluids and electrolytes and renal disorders will be presented.

Several special sessions including a symposium on children's television programming, plus meetings of the American Association of Poison Control Centers, and the AAP Council on Pediatric Practice are planned.

The Academy, with more than 12,500 members in the U. S., Canada, and Latin America, is the Pan-American association of physicians certified in the care of infants, children and adolescents.

Dr. Warren Will Head Emory Surgery

A Miami surgeon who is a former vice president and dean of medicine at the University of Miami has joined the Emory medical faculty as Joseph Brown Whitehead Professor of Surgery and chairman of the department of surgery.

Dr. W. Dean Warren, 46, comes to Emory from the position of professor and chairman of the department of surgery at the University of Miami. He had previously served as vice president for medical affairs and dean of the medical school at Miami in the period 1967-69.

In the Emory post, Dr. Warren replaces Dr. John D. Martin, Jr., who is retiring this year after an Emory affiliation of more than half a century.

Born in Miami, Dr. Warren attended elementary and high schools in Lakeland, Fla., receiving the A.B. degree at Dartmouth in 1947 and the M.D. at Johns Hopkins in 1950. He earned a Phi Beta Kappa key at Dartmouth and the equivalent for medical scholarship, Alpha Omega Alpha, at Johns Hopkins.

He held a John and Mary R. Markle Scholarship at the University of Virginia from 1956 to 1961. His primary research interests are in liver, pancreas, and blood vessel surgery, and he has served as principal investigator in these fields under two U. S. Public Health grants.

As an American Board certified surgeon (one year's residency in surgery at University Hospital, Ann Arbor, Mich., and three years at Barnes Hospital, St. Louis, Mo.) he has continued to practice his specialty with both staff and private patients. He was on the surgical faculty at the University of Virginia before moving to the University of Miami as professor and chairman of surgery in 1963.

In addition to his teaching and administrative duties, Dr. Warren will assume duties relating to surgical patient care at Emory-affiliated hospitals in Atlanta including Grady Memorial Hospital, Emory University Hospital, the Veterans Administration Hospital, and Henrietta Egleston Hospital for Children. He will be chief of surgery at the Grady and Emory University Hospitals.

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and Efudex® (fluorouracil) 5% cream can resolve it.

Call it actinic, solar or senile keratoses, many regard it as "precancerous."[1,2]

Topical fluorouracil, considered by some dermatologists to be a major advance in the treatment of multiple solar keratoses,[3,4] offers the physician a relatively inexpensive alternative to cryosurgery, electrodesiccation and cold knife surgery. Of the topical fluorouracils available, only Efudex offers 2% and 5% solution and 5% cream formulations—formulations that have proved effective in the treatment of these mutliple lesions.

Usual duration of therapy, 2 to 4 weeks.

Studies showed that with the 2% and 5% Efudex preparations, the usual duration of therapy was only 2 to 4 weeks.[5] Other studies with topical fluorouracil revealed that when concentrations of less than 2% were used, significant numbers of lesions recurred.[6]

Treats the lesions you can't see, too.

Numerous lesions, not apparent prior to 2% and 5% Efudex therapy, manifested themselves by definite reactions, while intervening skin remained relatively unaffected.[5] The early eradication of these subclinical lesions (which may otherwise have undergone further progression) probably accounts for the reduced incidence of future solar keratoses in patients treated with topical fluorouracil—especially with 5% concentrations.[6]

How to identify solar keratoses.

Typically, the lesion—a flat or slightly elevated brown to red-brown papule—is dry, rough, adherent and sharply defined. Multiple lesions are the rule.

Predictable therapeutic response.

The response to a typical course of Efudex therapy is usually characteristic and predictable. After 3 or 4 days of treatment, erythema begins to appear in the area of keratoses. This is followed by a moderate to intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of this response generally occurs two weeks after the start of therapy and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. Lesions that do not respond should be biopsied.

References: 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, Grune & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T, and Honeycutt, W. M.: "Treatment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *Pharmaceutical Therapeutics in Dermatology*, Springfield, Ill., Charles C Thomas, 1968, p. 92. 3. Belisario, J. C.: *Cutis, 6*:293, 1970. 4. Sams, W. M.: *Arch. Derm., 97*:14, 1968. 5. Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and Klein, E.: *Cancer, 25*:450, 1970.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

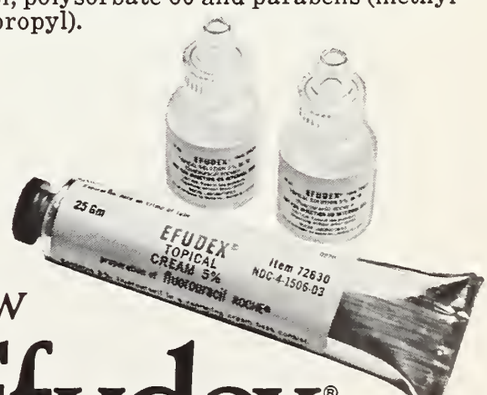
Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



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cream/solution

ACS Sets Clinical Congress for October

The world's largest meeting of surgeons will be held in Atlantic City, Oct. 18-22, with the opening of the 57th annual Clinical Congress of the American College of Surgeons.

Nearly 14,000 are expected to register for the five-day meeting, including 9,000 to 10,000 physicians from some 40 countries.

At the Atlantic City meeting, surgeons will hear more than 1,800 participants give lectures, study reports and demonstrations, all aimed at keeping the practicing surgeon abreast of "what's new" in the specialty of surgery.

The Forum on Fundamental Surgical Problems, which is concerned exclusively with original surgical research and investigation by young surgical investigators, covers 263 research-in-progress reports alone.

Other program features will include: 17 postgraduate courses given for younger surgeons by widely experienced teachers; more than 45 panel discussions and symposia on current problems in general surgery and surgical specialties by experts in the field; and more than 90 motion picture films and cine clinics, demonstrating noteworthy surgery in the United States, Canada and Mexico.

Also featured are a review of "What's New" in surgery; closed-circuit telecasts of actual operations from the Thomas Jefferson University Hospital, Philadelphia; approximately 450 scientific and industrial exhibits; special sessions on cancer, trauma, and undergraduate surgical education; general sessions on professional liability and the Surgical Education and Self-Assessment Program of the College which was designed to help Fellows (members) and other qualified physicians evaluate the extent of their basic and clinical knowledge in surgery.

Major addresses during the week will be given by the incoming president, Dr. Jonathan E. Rhoads, of Philadelphia; Dr. William A. Altemeier, Cincinnati, who will deliver the Scudder oration on trauma; Dr. Robert A. Good, Minneapolis, who will present the I. S. Ravdin lecture in the basic sciences; Dr. Philip Handler, Washington, D. C., who will deliver the Martin Memorial lecture, and Dr. Charles A. Berry, Houston, who will give the American Urological Association lecture.

A new feature on the College program this year will be a John H. Gibbon, Jr. lecture by Dr. Michael E. DeBakey, President of Baylor College of Medicine, Houston.

More than 1,400 surgeons will become Fellows of the College at the Convocation on Thursday evening. Fellowships are awarded to those who fulfill comprehensive requirements of acceptable medical education and advanced training as specialists in one of the branches of surgery, and who give evidence of good moral character and ethical practice.

For further information contact Sara Barr Cohen, Director of Publicity, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611. Phone: (312) 664-4050.

Dr. Silverio Named To Wyeth Communications

Wyeth Laboratories, division of American Home Products Corp., has appointed Dr. John Silverio to the position of associate director, medical communications, it was announced by Dr. Daniel L. Shaw, Jr., vice president of medical affairs.

In his new position, Dr. Silverio will organize, plan and conduct clinical studies on infant and other nutritional products and will assist the director of medical communications in the review of labeling and advertising and in handling correspondence of a medical nature on marketed products.

He joined Wyeth in 1963, with a broad background in medicine, including nine years of private practice, one year as a Fellow at the Pasteur Institute in Paris, France, two years on the medical staff of the Veterans Administration Hospital in New Orleans and one year as an assistant in tropical medicine at Tulane University School of Medicine. He received his M.D. degree in 1947 from the Havana University Medical School.

Dr. Silverio is a Fellow of the American Academy of Pediatrics, a Fellow of the College of Physicians of Philadelphia, an associate in pediatrics at the University of Pennsylvania School of Medicine, and a member of the American Therapeutic Society, the American Society for Microbiology, the American Medical Association, the Pennsylvania Medical Society, and the Chester County Medical Society.

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Southern Ob-Gyn Seminar Scheduled

The 17th Annual Southern Obstetric and Gynecologic Seminar will be held at Grove Park Inn, Asheville, N. C. Aug. 1-7, 1971.

Broad areas of obstetrics and gynecology will be discussed by a guest faculty including Drs. Bayard Carter and Roy Parker of Duke University; Dr. Robert Greenblatt of Georgia; Dr. Ed Tyler of California; Dr. Abe Mickal of New Orleans; and Drs. Robert Ross and Charles Hendricks of North Carolina.

Interested parties should contact the secretary, Dr. George T. Schneider, The Ochsner Clinic, 1514 Jefferson Highway, New Orleans, La. 70121.

Lederle Laboratories Receive Humanity Award

Lederle Laboratories Division of American Cyanamid Company was the recipient of San Francisco State College Alumni Association's "Humanity Award" for leadership and concern with environmental problems.

Dr. S. I. Hayakawa, president of the college, presented the plaque to William B. Currie, Lederle's regional manager for the Pacific Northwest.

In offering the award, Dr. Hayakawa noted, "We share a special concern for our environment here in California. Those who join in the battle to improve our ecology are the modern heroes of our time."

Lederle has sponsored medical symposiums to help alert physicians to the causes and problems of pollution-related illnesses.

Topics for the recent Oakland symposium included "The Clinical Aspects of Environmental Pollution," by Dr. John J. Hanlon, Assistant Surgeon General, Deputy Administrator, Department of HEW; "Illnesses of Noise and Crowding," by Dr. Beverley T. Mead, Chairman, departments of psychiatry and neurology, Creighton University School of Medicine; and "Environmental Influences on Future Generations," by Dr. Cecil B. Jacobson, Chief, Reproductive Genetics Unit, George Washington University School of Medicine.

Borden R. Putnam, general manager at Lederle, said of the symposium idea, "This environmental awareness program that we have developed is designed specifically to achieve the goal of being a good neighbor and also to provide a useful educational experience for members of the medical profession."

EEG Society Plans Annual Meeting

The American Electroencephalographic Society and the American Society of EEG Technologists (ASET) will hold their annual meetings Sept. 13-18 at the Hotel Radisson South in Bloomington, Minn.

Scientific sessions will include symposiums on psychological correlates of the EEG, generalized vs. focal electroencephalographic seizure activity, a joint session with ASET on the future of EEG technology, and a course on fundamentals of EEG technology.

For further information write Mrs. Margaret H. Henry, Executive Secretary, The American EEG Society, 36391 Maple Grove Road, Willoughby Hills, Ohio 44094.

Geriatrics Society Elects Officers

Dr. Francis P. Rhoades, family physician from Detroit, Mich., was chosen president-elect of the 8,000-member American Geriatrics Society recently at its 28th Annual meeting in Chicago. He will succeed Dr. Irving S. Wright, New York, N. Y., who was installed as president of the organization of medical specialists and allied health personnel interested in geriatric medicine.

Other officers elected by the membership were: Drs. William W. Priddle, Toronto, Ont., Canada, vice president; Alton Ochsner, New Orleans, La., treasurer and Edward Henderson, New York, N. Y., secretary.

Dr. Charles E. Lyght, Oklawaha, Fla., immediate past president, was elected chairman of the Board of Directors.

Newly elected as members of the Board were: Drs. Brock E. Brush, Detroit; Austin B. Chinn, Heathsville, Va.; Frederick G. Dorsey, Houston, Tex.; Max A. Hammel, Santa Barbara, Calif. and William Reichel, Baltimore, Md.

Chest Physicians Announce PG Programs

The American College of Chest Physicians has announced its 1971-1972 continuing education programs which have been approved by the Committee on Postgraduate Medical Education.

The programs have been developed in cosponsorship with leading medical schools and teaching hospitals and are geared to the physician and allied health professions with special interest and clinical needs in the areas of circulation, respiration and related disciplines. Each program will incorporate a variety of educational methods designed to insure active student participation in the learning process.

For further information, write ACCP, 112 East Chestnut Street, Chicago, Ill. 60611.

Federal Register Clarifies Medicare Services

Regulations recently published in the *Federal Register* will help clear up misunderstandings about the services that Medicare can pay for when an older person is in a nursing home or extended care facility.

Robert M. Ball, Commissioner of Social Security, said that the regulations formalize policies and guidelines developed and put into effect during the four-year period since the payment of Medicare extended care benefits began on Jan. 1, 1967, and are more detailed and explicit than earlier regulations.

In providing for the payment of extended care following hospitalization, the Medicare program introduced a new concept by financing the cost of a new level of care, Commissioner Ball pointed out.

"The type of care covered," he said, "is not the general run of nursing home care, but the level of care generally required during the last part of a hospital stay when the patient no longer requires full hospital services, but still needs to be cared for in an institution in which skilled nursing care is available on a continuous basis. The idea is to provide a less costly alternative to continued hospital care."

For Medicare to pay for his care, the elderly person in a participating extended care facility must need and must be receiving services that meet the definition of "skilled nursing services," the kind of care that can be given only by skilled nurses.

Medicare cannot, for example, pay for a stay in a nursing home or extended care facility if the person is in the institution simply because he needs help in eating, dressing, getting around, taking medicine, bathing, or taking care of similar needs. Also if skilled care is only needed on an occasional basis—for example, changing a special dressing once or twice a week—this in itself would not qualify the person for Medicare's extended care benefits.

The regulations point out that skilled nursing services are those furnished by a licensed nurse and include the observation and assessment of the patient's needs, the planning and management of a treatment plan, and giving direct service to the patient.

The required frequency rather than the regularity of skilled nursing services determines whether they can be considered continuous. For example, a patient may receive intramuscular injections every second day, but if this is the only skilled service he needs, the fact that he is receiving regular injections would not call for the continuing availability of a skilled nurse.

Observation of the patient's condition may be the principal continuous service when the unstabilized condition of the patient requires the skills of a licensed nurse to detect and evaluate the need for possible modification of treatment.

If an extended care facility is not sure whether Medicare can pay for a stay by a particular Medicare beneficiary, the institution may qualify to use a procedure for getting a quick decision from its Medicare intermediary by sending in a special request at the time of admission. More than half of the facilities certified to provide extended care under the Medicare program have qualified to use this procedure, Commissioner Ball said.

Medicare helps pay the bills for over 6 million hospital stays of older people each year, according to Commissioner Ball.

The average hospital stay by a Medicare beneficiary in fiscal year 1970, he said, was 12.9 days, down from an average of 13.4 the year before. In most cases, the older person is able to return home upon his discharge from the hospital. But in about 450,000 cases a year (seven-eight per cent), the Medicare beneficiary is admitted to an extended care facility following discharge from the hospital.

The average stay in an extended care facility is about five weeks and total Medicare payments for extended care amount to about $350 million a year.

Mr. Whitehead Returns to Board of Health

Dick B. Whitehead, a sanitarians and public health industrial consultant, has returned to Mississippi to help implement the Occupational Safety and Health Act of 1970—described as "one of the most important pieces of legislation ever passed by Congress."

Whitehead is president of the International Association of Milk, Food, and Environmental Sanitarians, holder of a citation from the American Society of Mechanical Engineers, and long-time chairman of the Committee on Sanitary Procedures of the 3-A Sanitary Equipment Standards Committees.

"The State Board of Health is fortunate to secure the services of Dick Whitehead at this time when our agency has been charged with the heavy responsibilities of implementing legislation that can be a great boon to over 800,000 gainfully employed Mississippians covered by its provisions," said Dr. Hugh B. Cottrell, State Health Officer.

"Very significantly and forcefully, the provisions of the law, referred to as PL-91-596, apply to every employer engaged in a business affecting commerce, with the purpose of insuring every employee safe and healthful working conditions and preserving our human resources," Dr. Cottrell noted.

The State Board of Health, he said, has been designated by Governor John Bell Williams as the state agency responsible for the implementation of the law, which involves the development of a comprehensive state plan and health and safety standards for industry, by the last of December 1972.

The actual administrative responsibility and program development, Dr. Cottrell stated, will be within the Division of Occupational Health under Director Huron L. Vaughan, with Whitehead as coordinator.

"There is no reason we cannot have a laudable program in effect by the deadline," said Whitehead, "—a program that will be not only a credit to Mississippi and the cooperative efforts of both regulatory agencies and industry, but also a model for the rest of the nation."

"If management will take the initiative and assess working conditions as they relate to health and safety from the obvious and reasonable point of view," he pointed out, "upgrading of any presently undesirable conditions will be accomplished in less time and with less disruption of routine."

With full cooperation of management, Whitehead predicts the program can be effective and efficient with the minimum of delay.

"The first steps in its accomplishment are well under way," Whitehead said. "A formal request, which includes plans for a state survey of facilities and manpower, including budget grant for the survey, has been forwarded to the Labor Department in Washington and is being acted on favorably."

"Companion to and in conjunction with this," he explained, "is the request for continuation of present state programs and regulations that will allow time to develop comprehensive plans and regulations equal to the standards issued by the Department of Labor, without our present regulations being subject to preemption by the Department of Labor."

"A graduate of the University of Missouri with both the B.S. and Master's degrees with major emphasis in microbiology and engineering, Whitehead was supervisor in the Division of Sanitary Engineering, State Board of Health, for 16 years, beginning in 1940, with time out for four years of military duty during WWII as a battalion commander in Armor.

In 1956, he entered industry as president and manager of a sales and production corporation and later, following a merger, served as manager and coordinator of programs and production.

He has been a consultant in public health, developing quality assurance and public health and safety programs for industry; designing processing plants, as well as sanitary and safe equipment; and developing functional specifications for computer data retrieval for Comprehensive Health Planning, involving all environmental aspects, including occupational health and safety.

Charleston Will Host ACP Regional Meeting

The 1971 Southeastern Regional meeting of the American College of Physicians is set for Oct. 7-9 in Charleston, South Carolina.

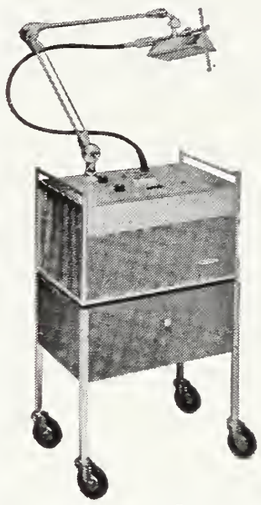
Headquartered at the Sheraton-Ft. Sumter Hotel, the scientific program will cover such topics as globulin disorders, clotting disturbances, portal hypertension, myopathies, seizures and vasculitis.

For further information write Dr. Vince Moseley, ACP Governor for South Carolina, Medical University of S. C., Charleston, S. C. 29401.

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IN CONCLUSION

Auto accident hazards to children is theme of new State Board of Health program. Data released disclose 30 child deaths last year for under-5 group in mishaps, most preventable. SBH calls for restraints for youngsters, especially in infant-to-five age bracket. American Academy of Pediatrics previously warned motoring public of dangers to children in sudden stops and minor accidents. Small fry need special restraints, since conventional belts seldom fit them.

Electromagnetic interference with pacemakers is being studied by scientists of Society of Automotive Engineers as a public service. Some 50,000 Americans use pacemakers, and demand or synchronous types which act only upon heart malfunction are vulnerable to radar, medical diathermy, radio transmitters, auto ignition, TV, and even electric shavers. Pacemaker manufacturers are furnishing units free for studies, and industrial laboratories are similarly available.

Southern governors live 20 per cent longer than the general public. In longevity studies of 856 governors entering office since 1900, Metropolitan Life actuaries found that nearly all state chief executives outlive general population except in Texas and Louisiana where mortality is 108 per cent of public at large. Life span of Mississippi governors is second only to those in New York and Pennsylvania. No wonder so many are running now for top office.

The doctor gets the patient's hospital bill in Sioux Falls, S. Dak. New program of Sioux Valley Hospital is aimed at involving attending M.D. in care management, so hospital business office sends him copy of his patient's bill to inform him of exact costs of hospitalization Hospital says program has resulted in some care cost reductions, especially in diagnostic tests and optional ancillary services. The professional staff says it understands cost patterns better, too.

Commissioned corps of U.S. Public Health Service may soon be abolished along with post of Surgeon General. Corps is actually a uniformed service with rank and commissions like armed forces. Currently, it consists of 5,500 officers among whom there are 2,575 physicians. U.S. Surgeon General Jesse Steinfeld opposes recommendation which would place career public health officers under civil service. Not generally known is fact that PHS is eligible for CHAMPUS benefits.

Volume XII
Number 9
September 1971



JOURNAL of the Mississippi
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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $7.50 per annum; $1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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Contraindications: Sulfonamide hypersensitivity; infants less than 2 months of age (except adjunctively with pyrime amine in congenital toxoplasmosis); pregnancy at term a during nursing period.

Warnings: Safe use in pregnancy has not been esta lished, and teratogenicity potential has not been thorough investigated. Sulfonamides will not eradicate or prevent s quelae to group A streptococcal infections, *i.e.*, rheuma fever, glomerulonephritis. Deaths from hypersensitivity rea tions, agranulocytosis, aplastic anemia and other blood dy crasias have been reported; early clinical signs such as sc throat, fever, pallor, purpura or jaundice may indicate serio blood disorders. Complete blood counts and urinalysis wi careful microscopic examination are recommended frequen during sulfonamide therapy. Clinical data are insufficient prolonged or recurrent therapy in chronic renal diseases children under 6 years.

Precautions: Use with caution in patients with impair renal or hepatic function, severe allergy, bronchial asthn and in glucose-6-phosphate dehydrogenase-deficient in

NEWSLETTER

September 1971

ear Doctor:

he Mississippi political scene was hit by a big bolt of lightning hen Gov. Williams announced possible special legislative session. ombshell came between primaries of lack-luster campaign, apparent- y related to neither gubernatorial candidate. Gov. Williams said hat chief business, if session is called, will be reorganization f executive department to decrease state agencies to 17 from 161.

> Nearly a fifth of senators and representatives would be lame ducks in a special session now. Gov. Williams sees this as advantage, however. Reorganization plan would dilute State Board of Health and divest it of medical licensure function, if reintroduced in present form.

efense Department has again demonstrated sound judgment in refus- ng to pay for abortion referral services under CHAMPUS. Referral gencies have sprouted like weeds in almost every state, funneling rospective pregnant patients into New York - for a fee. CHAMPUS ill pay for therapeutic abortions performed within limits of state aw. Claims for payment of referral services will be rejected.

ilm of President Nixon's challenging speech to AMA House of Dele- ates at Atlantic City is available for loan to medical societies. SMA has print which is 16 mm in sound and color with running time f 25 minutes. Highlights are blast at Sen. Kennedy's preposterous ationalized health bill and challenge to medical profession to help top drug abuse. To arrange free loan, write or call MSMA.

lorida has liberalized its tough medical licensure laws and will icense M.D.'s by endorsement, but restrictions still apply. Diplo- ates of National Board of Medical Examiners are eligible, as are icentiates from states using FLEX standard exams but only within ight years of original licensure. FMG's need U.S. residency train- ng, first citizenship papers, and ECFMG certification.

issisippi physicians have reacted with understandable protests ver the new restrictive Medicare policy on payment for injections. etter issued in August by Travelers Insurance, Part B carrier for issisippi, says program will pay only a flat $2 for services of hysician plus actual costs of drug injected and disposable syringe. ravelers says ruling was made by Social Security Administration.

Sincerely,

Rowland B. Kennedy
Executive Secretary

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Depression is a 24-hour-a-day problem... and disturbed sleep is often its nocturnal expression. In fact, such disturbance may be a key symptom in establishing the diagnosis of depression.



DATELINE

esearcher Calls or Drug Data Bank

Washington - A researcher has proposed that a drug abuse data bank recording information from urinalyses be established to formulate policy or fighting addiction. Dr. L. V. Vinebaugh wants every federally unded laboratory to cooperate, sending information for master com- uter at Washington. He claims that computer-processed information ould show what new drugs were being abused in what combinations and here among geographically identified population segments.

edicaid Must Pay or ADC Parent Care

Jackson - A federal court order has added 30,000 new beneficiaries to Mississippi's bare bones Medicaid program. District Judge Orma R. Smith as ordered state to provide care for needy parents and caretakers f dependent children. New service area could result in greatly ncreased payment frequency for obstetrical delivery, since nearly ll such parents are in child bearing years. Program has previously xcluded this category, since welfare payments are for the children.

alf of Donors et Blood Money

New York - Half of all Americans who give blood are bleeding for profit. So says the Health Insurance Institute which surveyed donors, finding hat 50 per cent sell blood. A meager 7 per cent give blood with no trings attached, and an estimated 43 per cent give blood for replacement, either for a specific patient in need of transfusion or nder blood assurance plans. Biggest bar to getting more donors toay are state laws requiring parental consent for those under 21.

ennedy Family M.D. s Neutral on NHI

Hyannis Port, Mass. - The Kennedy family physician denies that he is opposed to Sen. Edward Kennedy's nationalized health plan. Dr. R. D. att branded a report in the weekly Republican publication "Monday" hat he was dead set against the scheme of his patient as a "complete alsehood." Dr. Watt who has been personal physician to the Kennedy amily since 1955 said that he was interviewed by a man whose name e couldn't remember who caught him on a busy day.

iability Premiums oom in South

Montgomery, Ala. - Physicians in Alabama who do surgery are facing the steepest hike yet in professional liability insurance. Present rate for .00/300 coverage in Alabama is $1,399, and carriers propose 50 per ent premium increase to $2,200 annually. By contrast, present rate nder Mississippi's St. Paul program for same coverage is $650. Rate n Tennessee is $1,077 and in Georgia, $1,739. Standard carriers are ow filing for increases with Mississippi State Insurance Commission.

NAUI Schedules Second Diving Medicine Course

The National Association of Underwater Instructors will hold its second Diving Medicine course for physicians Aug. 21-28, 1971 in San Diego, Calif.

Dr. James J. Woodruff (USNR-R), NAUI Instructor and qualified Submarine Medical Officer, will direct the program. Course staff is expected to include Dr. George F. Bond, Special Assistant for Diving Medicine, Naval Ships Research and Development Laboratory, Dr. Bruce W. Halstead, director, World Life Research Institute, Dr. Albert R. Behnke, University of California Medical School, Dr. Stanley Gottleib, medical director for General Electric, Dr. S. Harold Reuter, otolaryngologist, Dr. Thomas Noguchi, medical examiner for the county of Los Angeles, Dr. Michael B. Strauss, staff medical officer for UDT and SEAL Teams on the west coast.

The primary objective of this eight day program taught by physicians for physicians is to eventually acquaint a major segment of the medical population with the problems of underwater physiology and therapy for diving and diving related injuries. Open to practicing physicians only, the course will include diving physics, venemous marine animals, diving physiology, advanced diving equipment, shallow-water blackout and drowning, decompression sickness, pulmonary physiology, decompression chamber operation, physical exams for divers, air embolism, treatment tables and other related subjects.

For those doctors with no diving experience an additional course in basic skin and scuba diving will be available. Time and arrangements will also be available during the course for diving in the San Diego area and nearby Mexican islands.

The first course of this type, held in the Bahamas, was completely filled 50 days beforehand. Interested physicians are encouraged to act promptly.

For information, write NAUI Headquarters, 22809 Barton Road, Colton, Calif. 92324, or call (714) 783-1862.

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and the Latin **sedatus,**
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Hypnosis Study Findings Reported

Childhood imagination, strict parents, and genetics may all be keys to whether a person can be hypnotized readily, according to research being supported by HEW's National Institute of Mental Health, Health Services and Mental Health Administration.

Dr. Josephine Hilgard, who with her husband Dr. Ernest Hilgard, heads a research team world-famous for its hypnosis studies, has found recently that persons who are easily hypnotized usually have similar backgrounds. As children, they frequently used their imagination to detach themselves from reality, and, although each had enjoyed a warm relationship with his mother, in many cases, severe discipline was part of the childhood picture.

Many persons who are easily hypnotized also report having learned as children to tune out unpleasantness, including parental punishment or lengthy scoldings. This suggests, says Dr. Josephine Hilgard, that some children develop the ability to "tune out" reality, and that this ability is sharpened by their need or desire to escape stress in their environment.

These findings—published in *Personality and Hypnosis,* University of Chicago Press, 1970, support earlier Hilgard data that indicate a major correlate of hypnotizability is the capacity to become deeply involved in some activity or interest such as reading, music, religion, or dramatics. In these pursuits, Dr. Ernest Hilgard says, "ordinary reality is temporarily set aside, as indeed it is in hypnosis."

More recently, a report on possible genetic influences on hypnotizability was contributed by Dr. Ernest Hilgard to the first issue of *Behavior Genetics,* a new professional journal devoted to the role of inheritance in behavior.

Based at Stanford University in California, the Hilgard team is one of the few research groups in the country dedicated to the study of the entire phenomenon of hypnosis and its practical applications.

One of the team's first undertakings was to find out why some persons are more susceptible to hypnosis than are others. The Stanford Hypnotic Susceptibility Scales are now widely used to measure how hypnotizable an individual is.

In addition to understanding the psychological mechanisms involved, the Stanford team is also interested in the practical applications of hypnosis, such as for relief of pain in childbirth, dentistry, and burns.

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Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or *bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in postsympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
September 1971, Vol. XII, No. 9

ORIGINAL PAPERS

Amebiasis Simulating Idiopathic Inflammatory Disease of the Colon

LARRY M. MITCHELL, M.D., and
LIDIO O. MORA, M.D.
Jackson, Mississippi

A series of nine cases of acute amebic colitis which were confused with idiopathic ulcerative disease of the colon is presented. Seven of the nine patients were from the Mississippi Delta. The history, physical examination, and laboratory tests were not helpful in making a specific diagnosis in these cases. All patients were thought radiographically to have idiopathic ulcerative disease of the colon. Fulminant amebiasis cannot be differentiated radiographically from idiopathic ulcerative disease of the colon. Specific therapy for amebiasis brings a prompt favorable response and antiamebic therapy should be used when the organism cannot be demonstrated if there is any doubt about the diagnosis.

ACUTE AMEBIC COLITIS is not a rare disease in rural parts of the United States where improper sanitary conditions exist. The usual course of this diarrheal disease is generally non-characteristic and therefore the diagnosis is often difficult.[1] Also, the complications of amebic colitis are those of any ulcerative disease of the bowel; namely, bleeding, perforation, and stenosis. In addition, toxic megacolon has been recently reported complicating amebic colitis[2, 3] and sporadic case reports of diffuse amebic colitis simulating idiopathic inflammatory disease of the colon have appeared in the literature.[4, 5] We have recently seen such a case and have reviewed our experience with this complication at the Veterans Administration Hospital and the University of Mississippi Medical Center in Jackson, Mississippi.

Case No. 1: C.D., No. 180597, UMC: This patient was a 23-year-old Negro female from the Mississippi Delta who presented herself at the University of Mississippi Medical Center emergency room on May 9, 1967, with a chief complaint of diarrhea of approximately one year's duration. The diarrhea was described as watery with gross blood, up to 10 stools per day, and associated with cramping lower abdominal pain. She had lost 15 pounds of weight during this illness. There was no history of arthralgia, skin or eye lesions. She had not been treated for amebiasis prior to her admission to the University of Mississippi Medical Center. Her family history was negative as well as systemic review and past history. Social history revealed that the patient had outdoor toilet facilities in close proximity to a well used for drinking water.

On physical examination she was a thin, chronically ill young female in acute distress. The

From the Departments of Medicine, Division of Gastroenterology, University of Mississippi School of Medicine, and Veterans Administration Hospital, Jackson, Miss.

pulse was 130 per minute and the temperature was 100 degrees Fahrenheit orally. There was evidence of dehydration. The cardiorespiratory examination revealed a tachycardia but otherwise was not significant. The abdomen was distended, but the bowel sounds were normoactive. There was a diffuse direct tenderness over the abdomen, greatest in the left lower quadrant. No organs or masses were palpated. The patient was incontinent of feces and rectal examination was deferred to proctoscopy.

When she was seen in the emergency room, stool was obtained and examined by the resident for ova, cysts, and parasites and was reported as negative.

The pertinent admission laboratory values are listed in Table 1. EPA and lateral chest films were interpreted as being within normal limits. Erect and supine films of the abdomen revealed dilated loops of large and small bowel with scattered air fluid levels. A barium enema was done on May 10, 1967, and is shown in Figure 1A. Diffuse ulceration of the colon was noted. Proctoscopy was performed on May 11, 1967, and revealed diffuse ulcerative disease of the rectosigmoid. There was suggestion of somewhat normal mucosa interspersed between the ulcerative bleeding necrotic areas in the rectosigmoid. A biopsy was obtained and is shown in Figure 1B. Stools that were collected on May 10, 1967, were subsequently reported as being positive for trophozoites of *Entamoeba histolytica,* and she was begun on antiamebic therapy. Blood transfusions and infusions of electrolytes were given. She responded and by the seventh hospital day was much improved.

On May 16 the patient was reproctoscoped by the gastrointestinal consultant. The rectal wall was friable and bled easily, and the bowel mucosa was denuded. It was the opinion of the endoscopist that the total picture represented severe amebiasis. The patient continued to improve and on May 19 sloughed a 12 to 15-inch section of mucosa per rectum. Microscopic examination of this specimen showed necrotic bowel mucosa containing numerous amebae. Patient was again proctoscoped on May 23 and the rectosigmoid appeared slightly granular but showed much im-



Figure 1A. Barium enema done on May 10, 1967, showing diffuse ulceration of the colon.

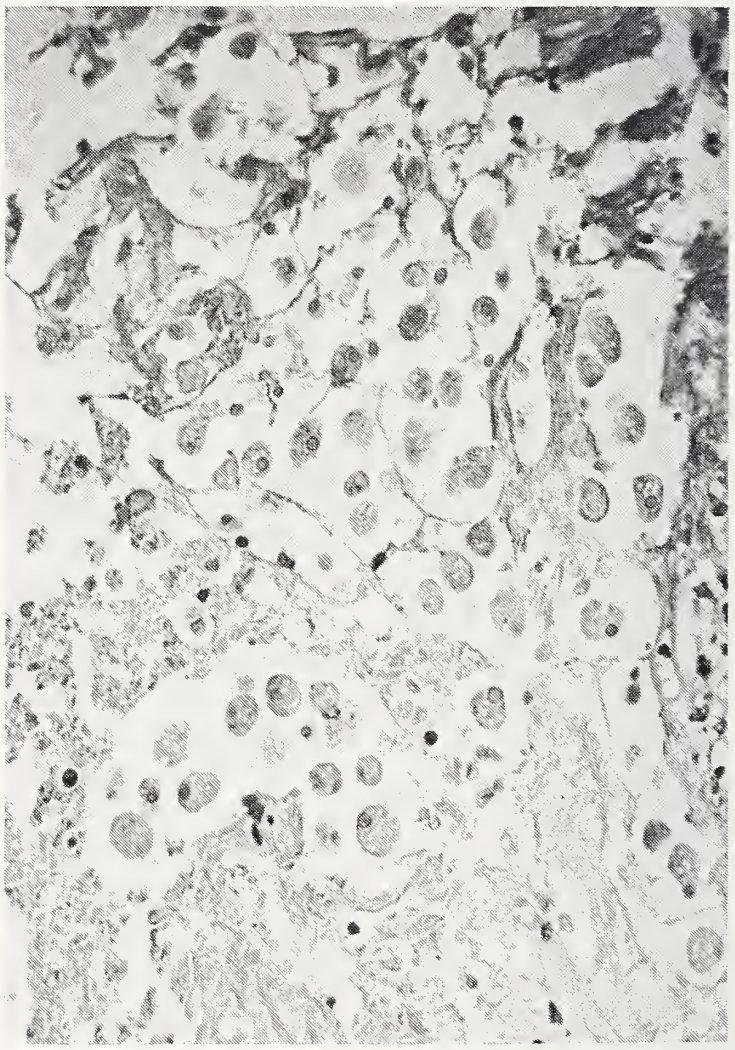


Figure 1B. Photomicrograph of biopsy taken at proctoscopy showing structures compatible with Entamoeba histolytica.

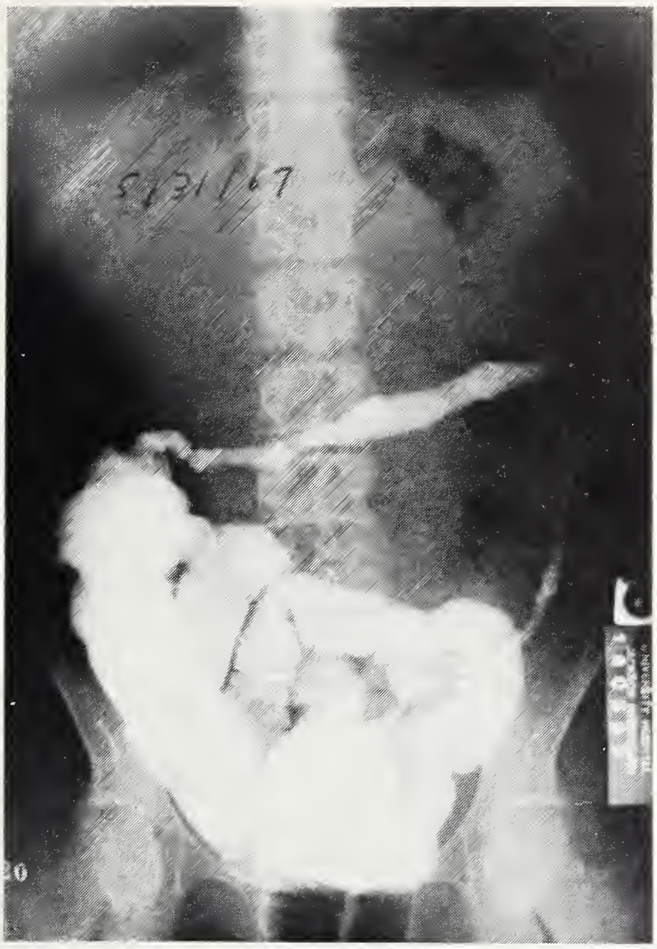


Figure 1C. Barium enema done on May 21, 1967, showing a small contracted colon compatible with idiopathic ulcerative disease.

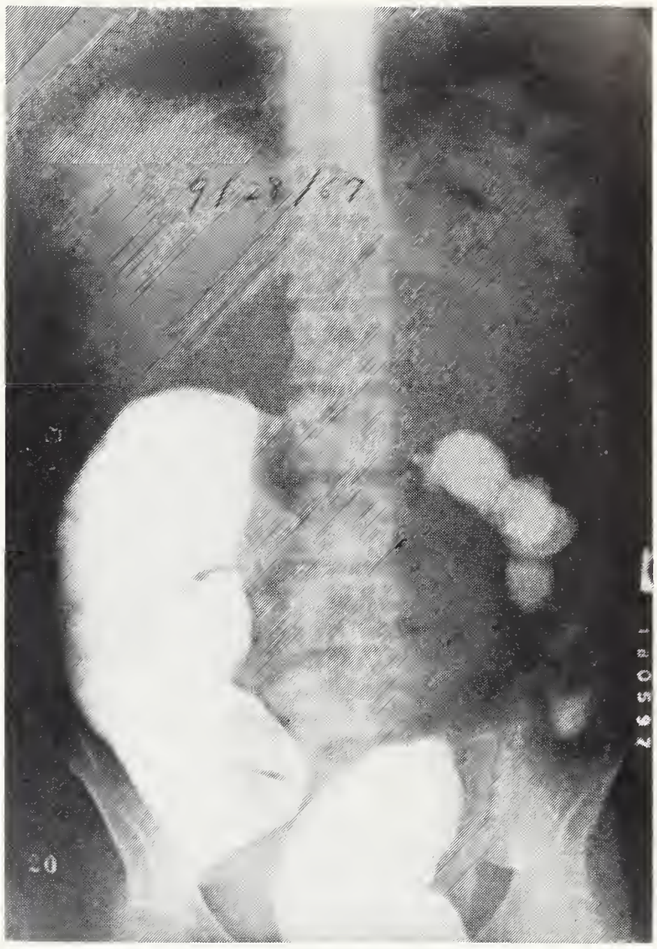


Figure 2A. Barium enema done on Sept. 29, 1967, thought to be compatible with granulomatous colitis.

provement. By this time the patient was asymptomatic and feeling well.

Just prior to discharge a repeat barium enema done on May 31 (shown in Figure 1C) demonstrated a small contracted colon with marked progression of the disease and was interpreted as being compatible with idiopathic ulcerative disease of the colon. The patient was discharged asymptomatic.

On June 22, follow up in the GI clinic revealed that the patient was asymptomatic and had gained three pounds. Repeat proctoscopy on July 20 revealed a stricture beginning at 12 cm. from the anal verge, but the patient was asymptomatic at that time and having one to two formed stools per day. By September 1967, however, she was having some abdominal distention with cramping left lower quadrant pain. Repeat barium enema was done on Sept. 28 and is shown in Figure 2A. This examination was thought to be compatible with granulomatous colitis. Patient was then readmitted for evaluation.

Proctoscopic examination was carried out on Oct. 2 and revealed a constricting lesion beginning at 14 cm. A biopsy was obtained and microscopic diagnosis was reported as severe chronic colitis. No organisms were demonstrated. Because of continuing lowgrade obstructive symptomatology, the patient underwent laparotomy on Oct. 12. At surgery multiple constrictions of the colon from the mid-ascending colon to 15 cm. above the anal sphincter were noted. The colon was scarred and narrow between the multiple constrictions. A 95 per cent colectomy was performed. The surgical specimen is shown in Figure 2B.

Microscopic examination is shown in Figure 2C. The microscopic examination was described as being compatible with granulomatous colitis although no granulomas were seen. Postoperative course was uncomplicated, and she was discharged to be followed in the outpatient department. She did well on follow-up and subsequently did not return for a clinic appointment. On the last visit to the GI clinic she was having normal bowel movements.

Case No. 2: E.C., No. 44938, Veterans Administration Hospital. This 42-year-old Negro man from Cleveland, Miss., was admitted to the ortho-

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pedic service of the Veterans Administration Hospital for osteoarthritis of the hip on Sept. 13, 1953. He was subsequently transferred to the medical service on Sept. 18 with a history of fever, abdominal cramps, and diarrhea associated with tenesmus which had been present intermittently since July 1953. On the day after admission to the orthopedic service he had an acute exacerbation of this diarrheal disease with 12 or more watery bowel movements daily, associated with some mucus and blood streaking.

Physical examination at the time of transfer to the medical service revealed diffuse abdominal tenderness without any spasm or masses. His temperature was 102 degrees Fahrenheit and there was a tachycardia. Rectal examination was difficult to perform because of extreme tenderness; however, there appeared to be a questionable nodular infiltrate on the rectal wall, but no other masses were palpated. The remainder of the physical examination was essentially unremarkable.

LABORATORY DATA

Laboratory data are depicted in Table 1. Numerous stools were negative for ova, cysts, and parasites, but positive for blood and mucus.

During the first 11 days the patient ran an irregular fever varying from 98.6 degrees to 103 degrees Fahrenheit. Proctoscopic examination was performed on Sept. 22 by a gastroenterology consultant and revealed an annular infiltrate about 3 cm. from the anal verge. The surface was friable and hemorrhagic with numerous nodular projections. It was impossible to advance the proctoscope beyond 5 cm. because of pain. The preliminary impression of the endoscopist was carcinoma of the rectum, although lymphopathia venereum, atypical amebiasis or atypical ulcerative colitis could not be excluded. Barium enema examination was performed on Sept. 27 and is depicted in Figure 3A. Findings were interpreted as far-advanced colitis.

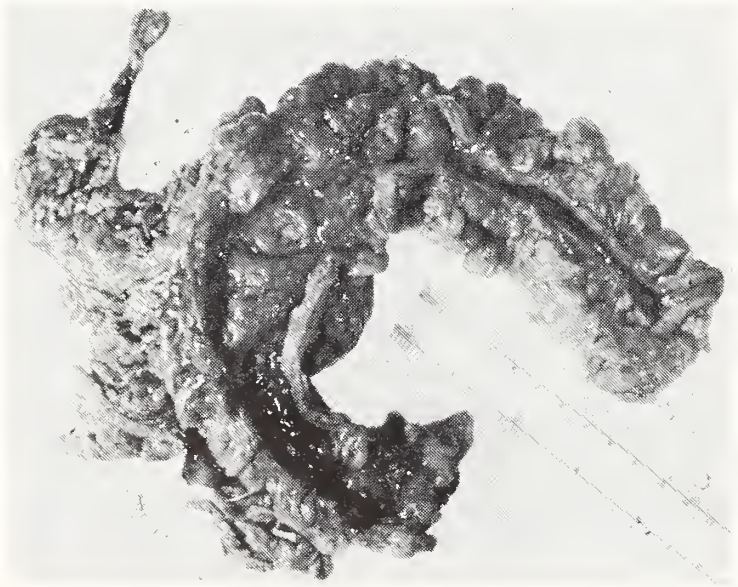


Figure 2B. Surgical specimen showing stricture formation.

ANTIAMEBIC THERAPY

Although no pathogens had been isolated, the findings were suggestive enough of amebiasis that he was given a course of antiamebic therapy. He immediately became asymptomatic and was subsequently given a leave of absence from Nov. 4 to Dec. 4. At the time of his return he had noted a 20-pound weight gain and had had no bowel disturbances at all. Repeat proctoscopy on Dec. 11 showed a narrowing of the lumen at 9 cm. by a tough annular stricture. The overlying mucosa

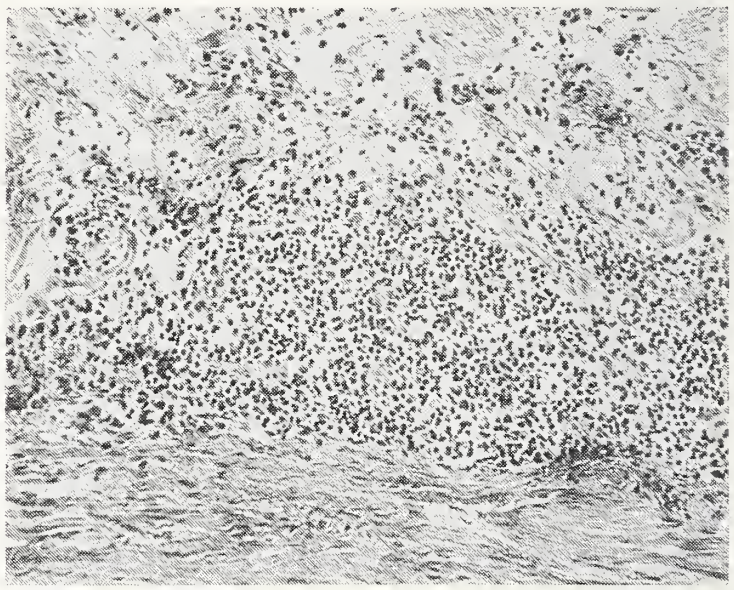


Figure 2C. Photomicrograph of specimen taken at surgery showing submucosal round cell infiltration. The vessels in this specimen were normal.

was intact and suggested a postinflammatory stricture. A repeat barium enema on Dec. 18 is shown in Figure 3B. Changes in the transverse colon suggested postinflammatory stricture. On Dec. 18, the patient was discharged asymptomatic to be followed as an outpatient. He was resigmoidoscoped in February 1954 and the stricture was again seen, and another examination in April 1954 showed the stricture to be dilated to about 2 cm.

He continued asymptomatic until June 1955 when he developed loose stools again. He presented himself to the Veterans Administration Hospital and on the day of admission he had had 18 bowel movements which were described as loose, watery, and dark brown in color. There had been no bleeding, chills, or fever, but the

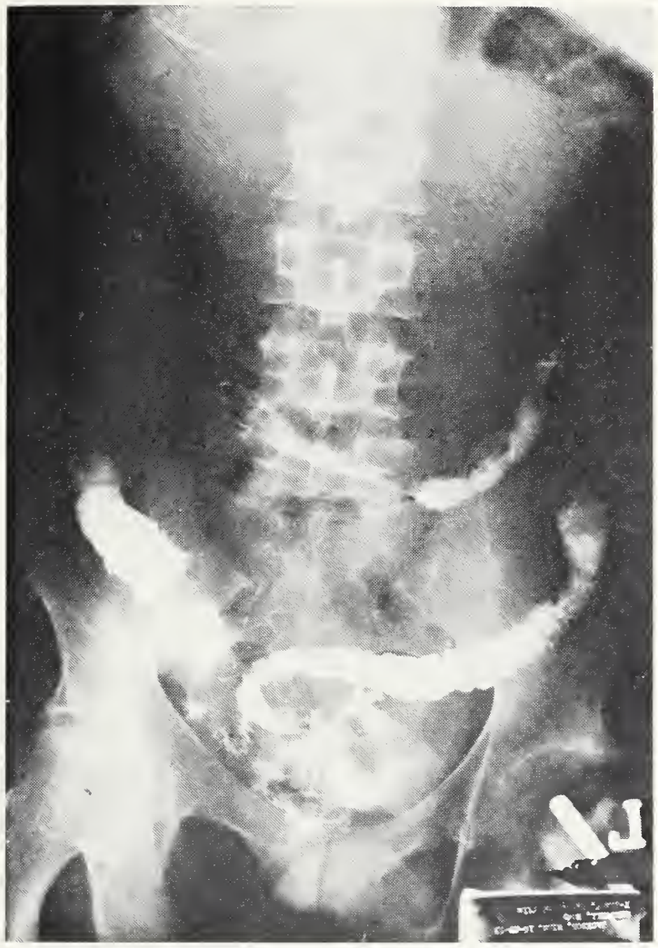


Figure 3A. Barium enema examination done on Sept. 27, 1953. Findings were interpreted as far advanced colitis.



Figure 3B. Barium enema examination done on Dec. 18, 1952. Changes in the transverse colon suggest postinflammatory stricture.

diarrhea had been associated with some lower abdominal pain. The appetite had been good up until the time of admission and he denied nausea, vomiting, weight loss, hematemesis, or jaundice.

On June 14, 1955, sigmoidoscopy revealed that the previously described postinflammatory stricture was still present, but the degree of opening was such that it was possible to pass the instrument past the stricture into the rectal, ampulla, and distal sigmoid. The mucosa was studded with many areas of ulceration, typically that of amebic colitis. No biopsy was taken.

He was subsequently given another course of antiamebic therapy and became asymptomatic. Stools for parasites were negative during this admission and no barium enema examination was done.

READMISSIONS

He was subsequently admitted to the Veterans Administration Hospital many times and followed through 1961 for orthopedic problems and had no further GI complaints. Follow-up barium enema examination was never done during these admissions, and he was subsequently lost to follow-up.

Case No. 3: G.W., No. 45476, Veterans Administration Hospital. The patient was a 58-year-old white man from Indianola, Miss., who presented on Nov. 12, 1953, with a chief complaint of bloody diarrhea of one week's duration. The patient stated that he had had the onset of weakness and diarrhea approximately one week prior to admission and that the diarrhea was accompanied by rather severe low abdominal gripping and aching. He had noted blood mixed with the stool as well as mucus for the period of the present illness. He stated that he had had one similar episode approximately two years prior to that time at which time he was admitted to the Kennedy Veterans Administration Hospital in Memphis, and was diagnosed as having amebiasis. Since that time, however, he had had intermittent cramping with short bouts of diarrhea but no severe attacks until the present illness. Systems review, past history, and family history were essentially not pertinent to the present illness.

On physical examination the blood pressure was 106/75, the pulse was 34, and he was afebrile. The patient was a slight, poorly nourished,

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chronically ill male who was oriented and cooperative. Physical examination revealed evidence of dehydration although the tongue was described as normal. Abdominal examination showed slight tenderness in the left upper quadrant. No masses or organs were palpated. On rectal examination the sphincter tone was very poor and tenderness was elicited on digital examination of the rectum. The prostate gland was of normal size and consistency and no masses were felt. The skin was very dry and of poor turgor; the rest of the physical examination was essentially unremarkable.

Laboratory data are described in Table 1. Numerous stools for ova, cysts, and parasites were reported negative, but positive for occult blood. On Oct. 16, 1953, the patient was proctoscoped to 16 cm. The mucosa was described as somewhat pale with small pinpoint ulcerations which bled easily. Specimens were taken from these areas and sent to the laboratory for examination. It was the impression of the endoscopist that this represented amebic colitis; however, the specimens taken at proctoscopy were reported as negative for ameba. Therefore some delay in scheduling treatment was encountered. Barium enema examination is shown in Figure 4A and was interpreted by the radiologist as indicating extensive idiopathic ulcerative colitis.

ENTAMOEBA HISTOLYTICA

Because of the inability to isolate the organism from the first stool examination and from the smears taken at first proctoscopy, he was reproctoscoped on Nov. 4 and smear from the ulcers at the time of proctoscopy revealed trophozoites of *Entamoeba histolytica.* A biopsy was not taken. He was then begun on therapy and before completing his first course of antiamebic therapy became completely asymptomatic. Repeat proctoscopic examination at the end of his hospitalization revealed normal appearing mucosa in contrast to the friable ulcerated rectal mucosa observed in the original proctoscopic examination. He was discharged asymptomatic on Dec. 4.

The patient was subsequently readmitted in January 1968 for gastroenterological evaluation. He was asymptomatic and the repeat barium enema shown in Figure 4B was normal.

CASE NO. 4

Case No. 4: W.D.S., No. 5236760, Veterans Administration Hospital. Feb. 10, 1954 was the first admission for this 31-year-old white man from Jackson, Miss., who presented with chief complaint of generalized aching, malaise, and diarrhea. The patient related that in January 1954 he had had an eruption which was diagnosed by his local physician as measles. This lasted for several days but subsided, and afterwards he felt weak, ran a low-grade fever and had profuse sweating each day. He then began to have loose bowel movements and subsequently was hospitalized for four days and received medications. The type of medication was unknown to the patient. He was told his weakness was due to the virus infection and that his laboratory work was all normal. He was discharged, and for the first week following discharge felt fairly well, gained some strength, and his diarrhea ceased.

Five days prior to his admission to the Veterans Administration Hospital, he developed abdominal distention followed by more diarrhea. He went to see his local physician who referred him to the Veterans Administration Hospital. On admission he related that there had been no associated tenesmus, and the stools had been characterized as liquid and watery. There was no nausea or vomiting, but his appetite had been very poor. He stated that he had lost 20 pounds of weight during the month prior to admission.

Physical examination revealed a blood pressure of 90/60 and the temperature 101

TABLE 1

Case No.	*Hct. Vol.%*	*Hgb. gm.*	*WBC/ cu.mm.*	*BUN mgm.%*	*FBS mgm.%*	*Ca meq/L*	*Na meq/L*	*K meq/L*	*CO_2 CP*	*Cl meq/L*	*Alb gm.%*
1. (C.D.)	48	14.3	19,000	11	89	4.2	131	3.6	34	90	2.5
2. (J.L.)	45	14	25,000	15.6	108	—	120	4.0	27.5	91	—
3. (A.M.)	37	11.0	7,200	28	126	—	150	3.0	—	111	—
4. (G.V.)	35	11.3	8,050	9	94	—	140	4.0	26	96	2.3
5. (G.W.)	—	12	9,400	—	—	—	—	—	—	—	—
6. (W.D.S.)	44	14	16,400	—	—	—	—	4.4	36	—	3.3
7. (J.N.)	44	17	12,750	20	93	—	—	—	—	—	—
8. (E.S.)	41	13.6	8,000	14	106	4.5	149	3.8	27	96	2.8
9. (E.C.)	45	15	22,000	—	—	—	124	5.1	20	94	—



Figure 4A. Barium enema examination done on Oct. 26, 1953, and interpreted as indicating extensive idiopathic ulcerative colitis.

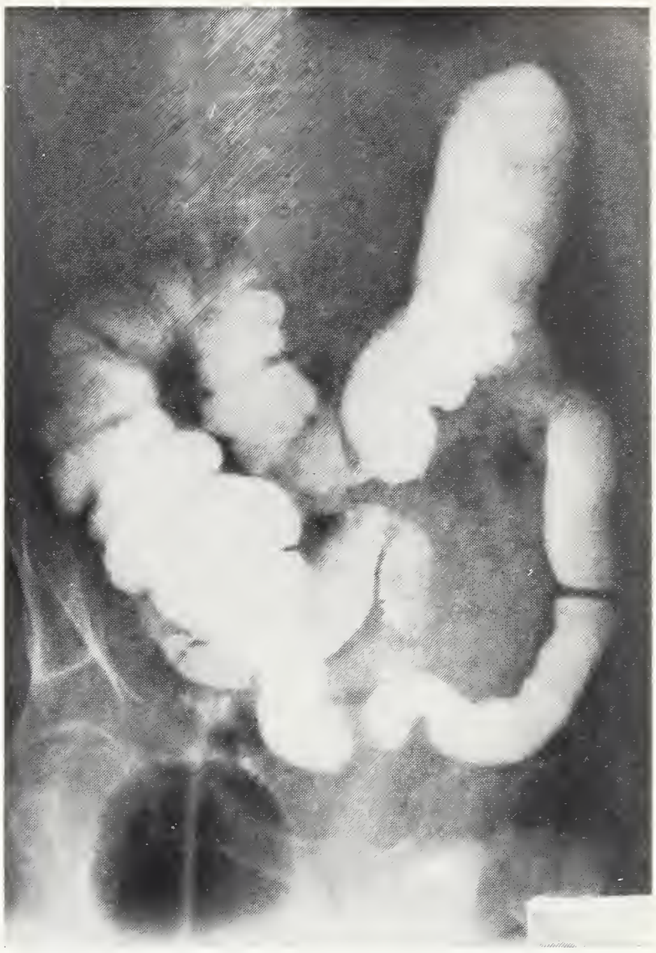


Figure 4B. Follow-up barium enema examination done in Jan., 1968, interpreted as normal.

degrees Fahrenheit. The patient was a dehydrated male in no acute distress. He complained of some abdominal discomfort. General physical examination revealed mild distention of the abdomen with some tenderness to moderate pressure over the entire abdomen. He had some increased peristalsis. No liver, kidney, or spleen was palpated. Rectal examination was described as normal. The rest of the physical examination was not remarkable. Pertinent laboratory data were completed on admission and are recorded in Table 1. Numerous stools were negative for ova, cysts, and parasites, and occult blood. Stool cultures were negative for enteric pathogens. X-ray examination of the chest showed the heart and lungs to appear normal. A barium enema examination performed on Feb. 19, 1954, is depicted in Figure 5A. Findings were reported by the radiologist as indicative of severe ulcerative colitis.

Following admission the patient continued to run a spiking type fever up to 102 degrees Fahrenheit which persisted for 11 days. He continued to have diarrhea, up to 8 or 10 loose watery stools per day. Proctoscopy was done and revealed small friable ulcers of the mucosa. No other lesions were seen. He was placed on penicillin and streptomycin and had no clinical response whatsoever.

ANTIAMEBIC THERAPY

Although no amebae were found, the patient was empirically started on antiamebic therapy and was treated for five days. This resulted in a prompt and sustained drop in the temperature with a rapid clearing of symptomatology. Proctoscopy was done after this regimen and revealed a normal appearing mucosa. The patient was discharged asymptomatic on March 23. His barium enema was repeated on March 19 and was reported as normal and is depicted in Figure 5B. The patient was then subsequently lost to follow-up.

Case No. 5: J.N., No. 2130, UMC. The patient was a 73-year-old white man from Kosciusko, Miss., who had had intermittent diarrhea for six years prior to admission to the hospital on Nov. 7, 1955. This diarrhea was interspersed with constipation of a rather severe degree. One year prior

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to admission he had the onset of almost constant diarrhea which was bloody, liquid in character, and associated with much mucus. He had had no formed stools in the year prior to admission to the University Hospital. He gave no history of anorexia or vomiting, and he had sustained a gradual weight loss from 156 pounds down to 136 pounds over the several months prior to admission. He also gave a history of vague left upper quadrant pain and a sensation of fullness across the epigastrium. Several days prior to admission, he had the onset of sudden and severe rectal hemorrhage, was taken to his local physician and subsequently referred to the University Medical Center.

There was no family history of diarrhea and no history of tuberculosis or carcinoma. Social history and review of systems were essentially negative.

PHYSICAL EXAMINATION

On physical examination the patient was a slightly underweight man in no acute distress. The turgor and elasticity of the skin were described as good. There was no stigmata of anemia. On examination of the abdomen, the liver, kidney, and spleen were not palpable. There was a diffuse tenderness to palpation over the epigastrium and left upper quadrant, but no masses were felt. Bowel sounds were hyperactive and after rectal examination, which was described as normal, the patient was proctoscoped. An annular constriction was seen 4 cm. above the anal verge with multiple ulcerative lesions with whitish-yellow bases. The scope was not passed beyond this constriction and the impression at the time of the endoscopic procedure was amebic colitis.

LABORATORY STUDIES

Routine laboratory studies are depicted in Table 1. Numerous stools for ova, cysts, and parasites were done with no pathogens being isolated. Barium enema examination was performed on Nov. 9. It was interpreted by the radiologist to reveal rather extensive inflammatory process involving the entire colon. Shortening of the overall length of the colon and almost complete absence

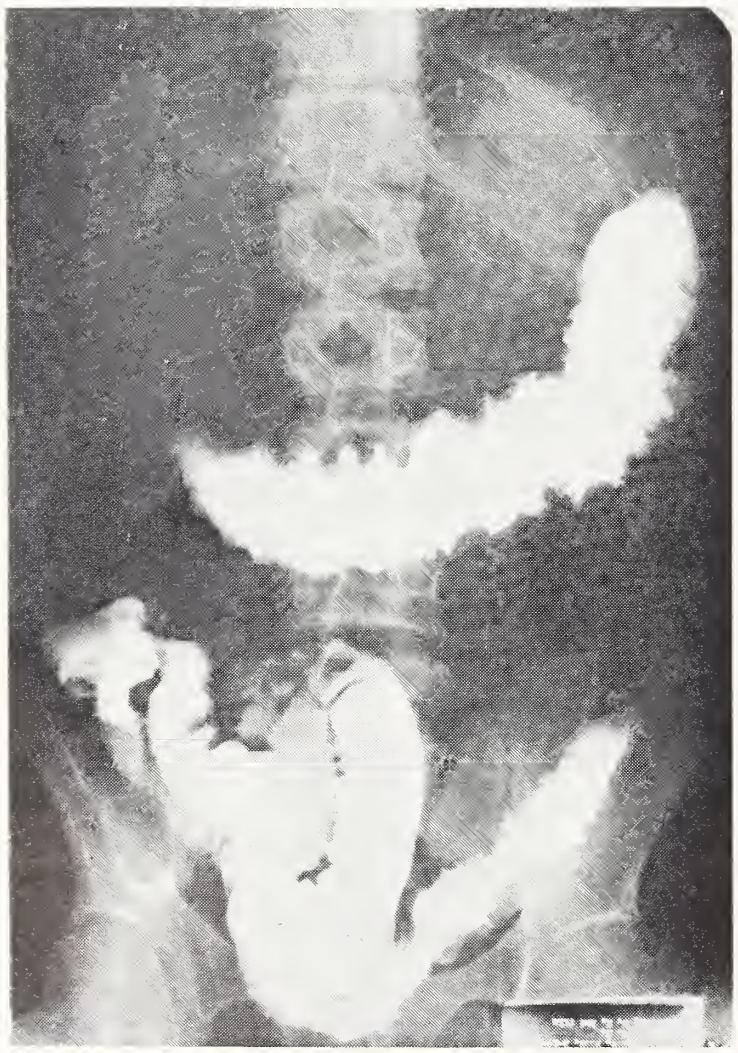


Figure 5A. Barium enema examination done on Feb. 19, 1954, showing diffuse ulceration of the colon, reported as severe ulcerative colitis.

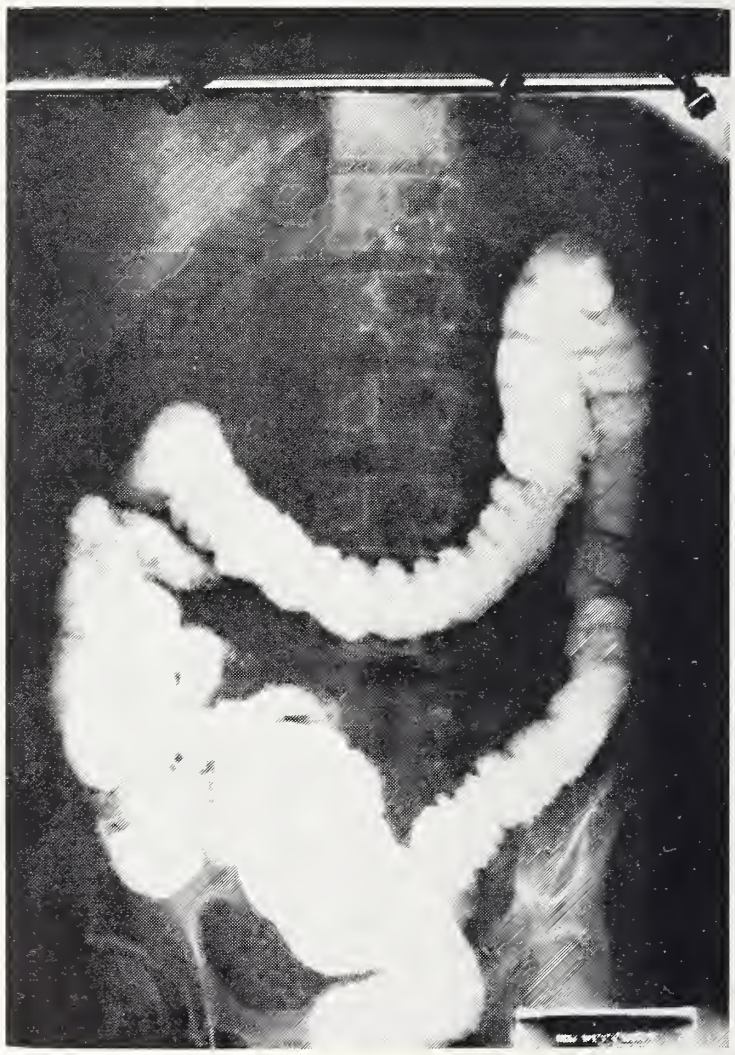


Figure 5B. Barium enema examination done on March 19, 1954, reported as normal.

of the normal haustral markings was noted. It was the impression of the radiologist that this represented chronic idiopathic ulcerative colitis. Chest film and electrocardiogram were not remarkable.

On Nov. 7, the patient was reproctoscoped and material obtained from these ulcerative lesions showed definite trophozoites of *Entamoeba histolytica.*



Figure 6A. Barium enema examination done on Nov. 6, 1957, showing diffuse ulceration of the colon.

The patient was then started on therapy for amebiasis and had a prompt and sustained response. Repeat proctoscopy later in his hospital course revealed marked improvement. He became asymptomatic and was discharged on Nov. 19 to be followed on an outpatient basis. The patient was subsequently lost to follow-up.

Case No. 6: J.L., No. 73020, Veterans Administration Hospital. This was a 71-year-old Negro male from Belzoni, Miss., who was admitted on Nov. 1, 1957, with one month's history of bloody diarrhea of increasing intensity associated with tenesmus and a dull aching lower quadrant pain. He had had a 20-pound weight loss over the year prior to admission. The patient had been nauseated but denied vomiting.

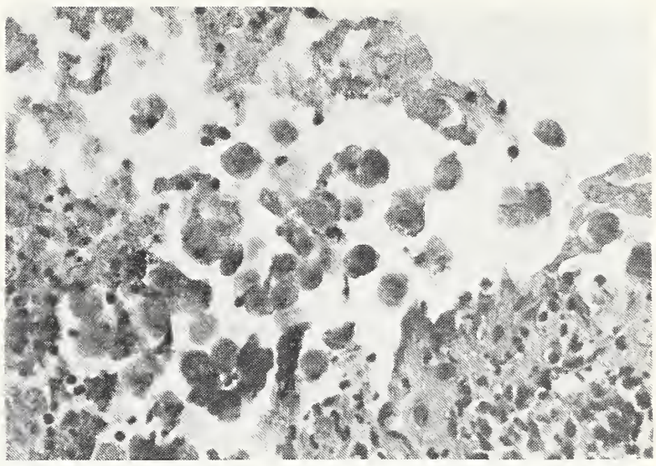


Figure 6B. Biopsy of rectosigmoid showing trophozoites of Entamoeba histolytica.

On physical examination the patient was seen to be a chronically ill Negro male in no particular distress. He was afebrile. The general physical examination was not remarkable. On digital examination the rectal wall was described as indurated in all directions.

Pertinent laboratory data are listed in Table 1. Four stools were reported negative for ova, cysts, and parasites. A barium enema examination was performed and is shown in Figure 6A. Diffuse ulceration was noted. Proctoscopy was done on Nov. 5, 1957, and revealed a nodular granular mass which was encountered at 8 cm. and was described by the endoscopist as having the "appearance of a carcinoma." Biopsy of this mass shown in Figure 6B subsequently showed no evidence of malignancy but did reveal trophozoites of *Entamoeba histolytica.* Stools were subsequently positive for the parasite.

Treatment up until that time had been for idiopathic ulcerative colitis with no response. He was then started on an antiamebic regimen. Despite these measures, the patient went downhill and died on Nov. 15.

BOWEL PERFORATION

At post-mortem, multiple areas of perforation of the large bowel were seen. The entire mucosa of the large bowel showed a segmental distribution of extensive involvement by flat shaped ulcers which in places fused to form large confluent ulcerations. Microscopic examination of the colon showed all stages of amebic colitis from early invasion to goblet ulcer formation, on to complete destruction of large segments of the colonic mucosa.

Case No. 7: A.M., No. 10807, Veterans Ad-

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ministration Hospital. This was the first admission for this 74-year-old Negro man from Sondheimer, Louisiana (Mississippi River Delta region), who was admitted to the Veterans Administration Hospital with a chief complaint of diarrhea on July 5, 1962. The stools were allegedly watery without blood or mucus. No other gastrointestinal symptomatology was elicited.

Physical examination revealed an afebrile Negro male in no distress. General physical examination was not remarkable, and in particular the abdominal examination was described as negative. There was a questionable mass palpated on digital examination of the rectum. Laboratory data are listed in Table 1.

Repeated stools for ova, cysts, and parasites were negative but were positive for occult blood. Stool cultures grew no pathogens. Sigmoidoscopy was performed soon after admission and the mucosa of the rectosigmoid was described as very red with areas 1 to 2 cm. in diameter that exuded purulent exudate. Figure 7A shows the barium enema that was performed on July 9, 1962. It was interpreted as being compatible with extensive idiopathic ulcerative colitis.



Figure 7A. Barium enema examination done on July 9, 1962, interpreted as being compatible with extensive idiopathic ulcerative colitis.

The patient's course in the hospital was downhill. The patient was treated for bacterial colitis with antibiotics. On the tenth hospital day the abdomen became distended and silent. Laparotomy was performed on July 16 and revealed two perforations in the distal colon. Material aspirated from the peritoneal cavity at surgery showed trophozoites of *Entamoeba histolytica.* He died in the immediate postoperative period on July 18. A postmortem was denied, but the surgical specimen was compatible with amebic colitis and is shown in Figure 7B.

Case No. 8: G.V., No. 128659, UMC. This was the first admission for this 44-year-old white female from Yazoo City, Miss., who was admitted to the University Medical Center with a swollen abdomen and fever on March 19, 1964. Patient had begun to have diarrhea four to five years prior to admission. This diarrhea was characterized by exacerbations and remissions,

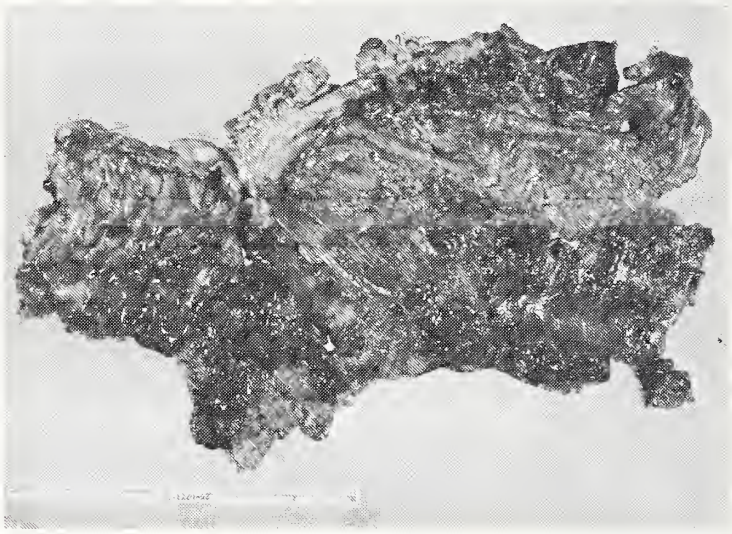


Figure 7B. Surgical specimen showing multiple ulcerations compatible with amebic colitis.

and had never required hospitalization. However, for three weeks prior to admission, she had had an increase in the diarrhea and was having 8 to 12 bloody stools per day. Past history and family history revealed only that a daughter had had amebiasis in the remote past.

On physical examination the patient appeared moribund. Temperature was 103 degrees Fahrenheit orally. Pulse was 110 and the blood pressure was 100/60. There was evidence of marked dehydration. The abdomen was markedly distended with hypoactive bowel sounds. No organs or masses were felt, but diffuse tenderness was noted. Proctoscopy was done and the mucosa was described as erythematous, and at 12 cm. two ul-

cerations were encountered. Biopsies were obtained of these two ulcerations.

Laboratory values are detailed in Table 1. Stools were negative for ova, cysts, and parasites. Biopsy obtained at the proctoscopy showed nonspecific changes, and in particular no amebae were noted. Material obtained at proctoscopy was also smeared and no amebae were found. Figure 8A shows a spot film of the rectosigmoid done on April 1, in which diffuse ulceration was seen. It was the opinion of the radiologist that this was compatible with idiopathic ulcerative colitis.

It was felt, however, by the attending physician that the total picture was also compatible

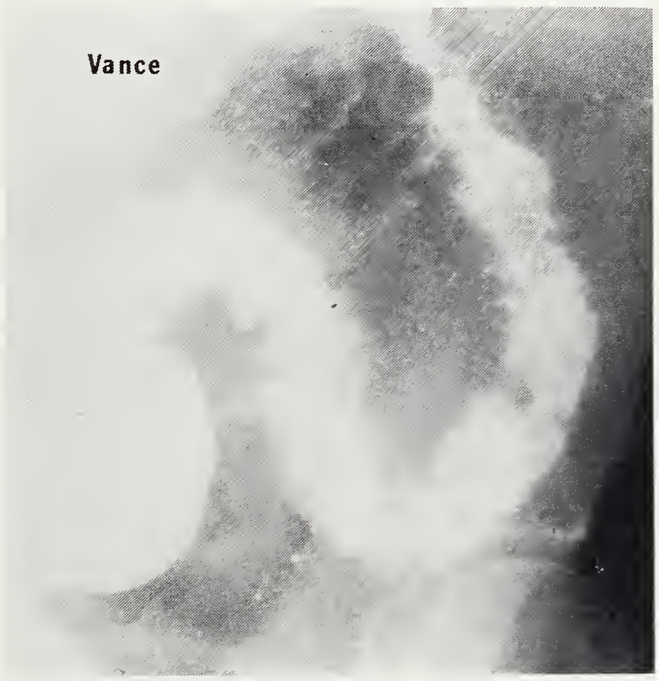


Figure 8A. Spot film of the rectosigmoid done on April 1, 1964, showing diffuse ulceration interpreted as compatible with idiopathic ulcerative colitis.

with amebic colitis even though the organism had not been demonstrated. She was then empirically started on antiamebic drugs and had an immediate response to therapy. Repeat barium enema on July 2 is shown in Figure 8B and was interpreted as normal. Proctoscopy at that time was also thought to be normal. She was subsequently discharged as asymptomatic on April 10 and follow-up examination revealed no bowel disturbances whatsoever.

Case No. 9: E.S., No. 129135, UMC. March 31, 1964, was the first University Hospital admission for this 55-year-old Negro man from Indianola, Miss., with a chief complaint of diarrhea. The patient dated the onset of his illness back to 1939 when he was operated on for hemorrhoids. A



Figure 8B. Follow-up examination done on July 2, 1964, showing normal colon.

few months later in 1940 he developed diarrhea with up to 15 to 20 bowel movements per day. Stools contained varying amounts of blood and mucus, and he was treated with different medicines to little or no avail. In spite of this intermittent symptomatology and the length of his illness, he had maintained his weight in the range of about 150 pounds. He stated that during the past 25 years he had not been symptom free for more than two weeks at a time. Other past history and family history, social history and systemic review were not thought to be pertinent to the present illness.

PHYSICAL EXAMINATION

Physical examination revealed a blood pressure of 140/90, pulse 86, and temperature of 98.6 degrees. Patient was a well developed, well nourished, somewhat thin Negro male in no apparent distress. General physical examination was not remarkable, and in particular the abdomen was soft and flat. Liver, kidneys, nor spleen was felt and no masses or tenderness were noted. Bowel sounds were normoactive and the rectal examination was not remarkable. The patient was then proctoscoped to 10 cm. The mucosa was described as very friable and there were copious amounts of blood and mucus.

Laboratory values are recorded in Table 1. Stools were repeatedly negative for ova, cysts, and parasites. Biopsy of the rectal mucosa depicted in Figure 9A was obtained and showed structures suggestive of *Entamoeba histolytica.* Barium enema examination was performed on March 31, 1964, and is shown in Figure 9B. This was thought to represent idiopathic ulcerative colitis by the radiologist.

Since the patient was initially thought to have idiopathic ulcerative colitis, he was started on therapy for this entity. However, after the biopsy of the rectal mucosa was returned, he was started on antiamebic therapy and soon became asymptomatic. Repeat sigmoidoscopy was done and showed normal appearing bowel mucosa to 24 cm. Repeat barium enema on April 6 was reported as within normal limits, and is depicted in Figure 9C. Patient was then discharged asymptomatic on April 15 and the discharge diagnosis was amebic colitis. Follow-up on June 12 revealed the patient was asymptomatic.

DISCUSSION

The above cases point out some of the difficulties encountered by the physician who is caring for the patient with a diarrheal disease. There was a disparity between the findings on initial history and physical examination and the severity and outcome of the illness in these patients. As noted in Table I, in patients six, seven, and nine, the initial physical examination of the abdomen was described as not remarkable although two of these patients subsequently died. Patients one, four and eight had distended, tender abdomens with decreased bowel sounds and all recovered with appropriate therapy. No extracolonic manifestations were recorded in any of these patients in this series.

The stool examination for ova, cysts, and parasites was initially negative in eight of the nine presented cases although all had extensive active amebiasis. Many antibiotics will temporarily eradicate amebae from the stool, and this may have contributed in Cases 4 and 7 although both had stool examinations prior to therapy with antibiotics. Mineral oil preparations before radiologic examination and barium itself have been reported to render stool specimens unsatisfactory for examination for ameba.[7] All of the above cases had stool examination prior to preparation for barium enema. The high incidence of negative stool examination in these patients with fulminant amebiasis makes one wonder if technical errors in collection and examination alone are responsible.

BIOPSY

Biopsy at sigmoidoscopy has proved an effective means of establishing a diagnosis of amebiasis.[8, 9] In three of the four cases in the above series where biopsy was obtained at sigmoidoscopy, a positive diagnosis of amebiasis was made. Smears of material obtained at sigmoidoscopy were positive in two of the above cases where biopsy was not done.

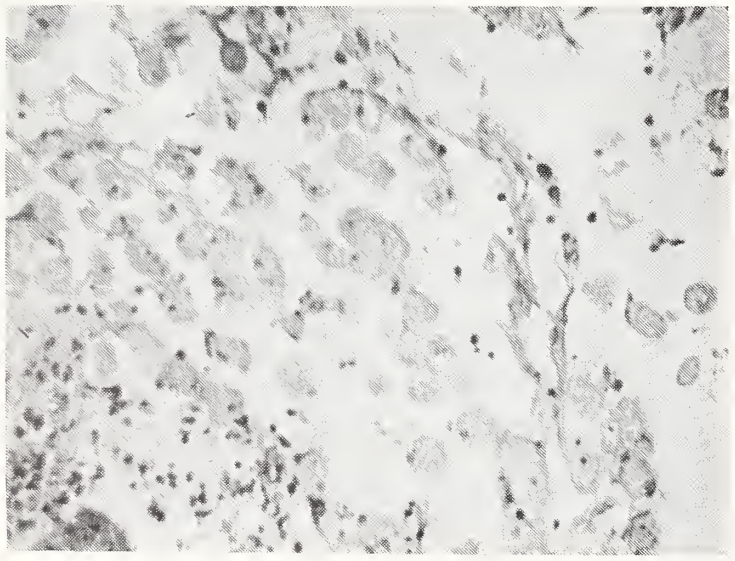


Figure 9A. Biopsy of rectal mucosa showing structures suggestive of Entamoeba histolytica.



Figure 9B. Spot film of rectosigmoid taken at barium enema examination on March 21, 1964. Diffuse ulceration thought to represent idiopathic ulcerative colitis was reported.

Radiologically all the patients in this series were thought to have idiopathic ulcerative disease of the colon. In acute fulminating amebic colitis the barium enema examination resembles idiopathic ulcerative disease of the colon and the two entities cannot be differentiated radiographical-

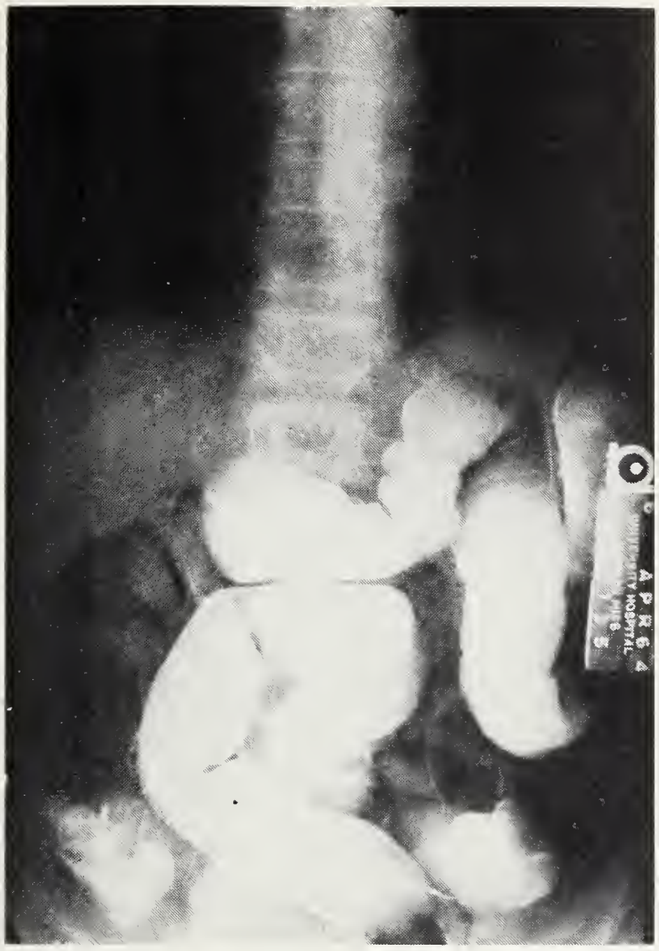


Figure 9C. Barium enema follow-up done on April 6, 1964, reported as being within normal limits.

ly.[10, 11] The follow-up barium enema examination in Case 1 was compatible with a diagnosis of either granulomatous colitis or vascular ischemic colitis although the clinical course and pathologic findings make these unlikely possibilities. The clinical course is not as clear cut in Case 2 as an underlying ischemic colitis or granulomatous colitis with superimposed amebiasis is a possibility.

Seven of the above nine cases were from the Mississippi Delta. (See Figure 10.) The disease is thought to be endemic in temperate climates.[12] Extensive rural areas and lower socioeconomic conditions may contribute to the higher rates in the southern United States.[13] Improper sanitation rather than an association with a tropical climate is reflected in the high incidence of amebiasis in Canadian Indians.[14]

RESPONSE TO THERAPY

The response to specific antiamebic therapy was almost uniformly dramatic in the above patients. In three patients where the organism was not found, empiric antiamebic therapy brought a prompt favorable response.

Only one patient (Case 7) was operated upon in the above series and died immediately postoperation. He had received no antiamebic thera-

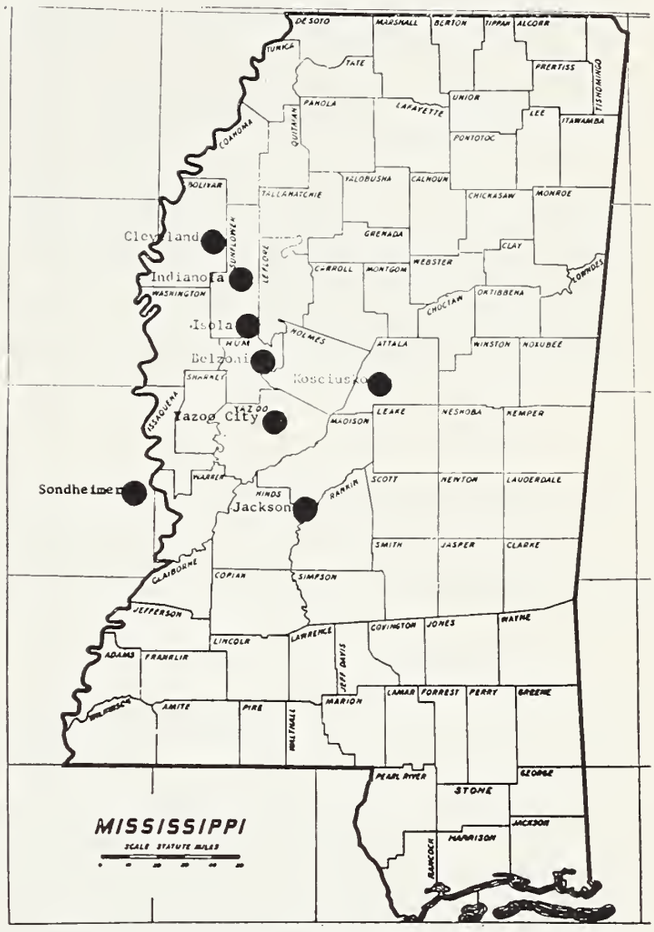


Figure 10. Map of Mississippi showing residences of patients in this series; seven of nine patients were from the Mississippi Delta.

py but had been on antibiotics. Material obtained from the peritoneal cavity at operation was positive for ameba. The surgical mortality in the 1933 Chicago epidemic was reported as 43 per cent,[15] and the hazards of surgical intervention in unsuspected amebiasis have been reported.[16]

With more and better methods of diagnosis and therapy, more cases resembling idiopathic ulcerative disease of the colon or ischemic colitis may be encountered as depicted in Case 1 and possibly Case 2 in the above series. Reference is made to the rapid development of segmental colonic strictures in Case 1. ★★★

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THE WAY TO GET RESULTS

There once was a very wealthy lumber baron who sent word to his four married sons to return home for a conference. After they were all seated at the dining table, he told them, "I am a very old man and I have long been disappointed that I have no grandchildren. Tomorrow, I am making out my will and I am leaving $50,000 to the couple that presents me with my first grandchild. Now, I'll say grace and then we shall eat." So he bowed his head and said a short prayer. When he looked up, EVERYONE WAS GONE.

Granulomatous Tenosynovitis in Coastal Mississippi

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This paper cites four cases of granulomatous tenosynovitis involving the hand and forearm. In each case, no mycobacteria could be cultured at 37°C. and the injured person had been involved with salt water. The authors feel the infections resulted from an aquatic mycobacterium, possibly M. marinum, and suggest culturing at room temperature and 32°C. as well as 37°C.

Over the past five years, we have observed four cases of granulomatous tenosynovitis involving the hand and forearm. In each case, the illness began, or may have begun, following a minor injury sustained while fishing or working in salt water. Acid fast organisms were demonstrated in tissue obtained from two cases; however, no mycobacteria were cultured at 37°C. in any of the cases. We feel that these cases represent infection with an aquatic mycobacterium, possibly M. marinum.

Case No. 1, A 38-year-old fur trapper was hospitalized with a three month history of swelling involving the volar surface of the left wrist, thumb, and second and third finger. This illness followed, at an unknown interval, a minor injury from a fish fin. Treatment with antibiotics and immobilization had proven ineffective. In December of 1964, a synovectomy was performed. Microscopic examination of the excised tissue showed the "presence of numerous granulomatous tubercles with fairly discrete Langerhans' giant cells." Special stains for acid fast organisms and fungi were negative. Culture at 37°C. for mycobacteria were negative. The patient was treated with chloramphenicol and discharged.

In April of 1965, swelling involving the right wrist and extension sheaths of the thumb and forefinger developed. Again, synovectomy was performed. "Necrotizing synovitis, presumably rheumatoid," was found. The disease process, however, was felt by the pathologist not to be completely characteristic of rheumatoid arthritis. Cultures at 37°C. for mycobacteria were negative. The latex test for rheumatoid arthritis was positive in a 1-80 dilution. The patient was discharged and lost to follow-up.

Case No. 2. A 54-year-old nurse injured her left hand in the summer of 1968 while pulling up an anchor rope. One week later, she noticed a sore in her left palm. Treatment included excision and drainage. "A mycin drug" was prescribed by her physician. In spite of this treatment, a palmar space infection developed. In October, she was hospitalized with tenosynovitis involving the flexor tendons of the right hand and wrist. Microscopic examination of the excised tissue revealed a nonspecific granulomatous reaction. Acid fast bacilli were not found. Cultures were not taken. She was treated with chloramphenicol and discharged.

In December, she noticed swelling in the area of the previous surgery. She was hospitalized and the area incised. A granulomatous reaction was again noted. Special stains for acid fast organisms were positive. Cultures however, were negative at 37°C. for mycobacteria. She was treated with INH and bi-weekly streptomycin for nine months and has noted no recurrent disease.

From the Departments of Internal Medicine and Orthopedic Surgery, Singing River Hospital.

Case No. 3. A 55-year-old male developed a swollen, tender, right wrist and forearm in February of 1969. He could recall no definite injury to that area, but had been fishing on numerous occasions immediately preceding his illness. He was hospitalized and a synovectomy was performed. A granulomatous tenosynovitis was noted. No acid fast organisms were demonstrated. Cultures for mycobacteria at 37°C. were negative. The patient was treated briefly with chloramphenicol and discharged.

In January of 1970, he was admitted to the Singing River Hospital with a three week history of recurrent lower gastrointestinal bleeding. He was also noted to have a 1½ cm. nodule on the right forearm and several ½-1 cm. axillary lymph nodes. A complete gastrointestinal work-up was negative. The PPD intermediate was positive. Excision of the nodule revealed a granulomatous reaction. No acid fast organisms were demonstrated. Cultures were negative at 37°C. He was treated with INH and bi-weekly streptomycin for six months and has noted regression of his axillary lymphadenopathy and no recurrence of his tenosynovitis.

Case No. 4. A 42-year-old male stuck a fish fin in his right thumb. Ten days later swelling and

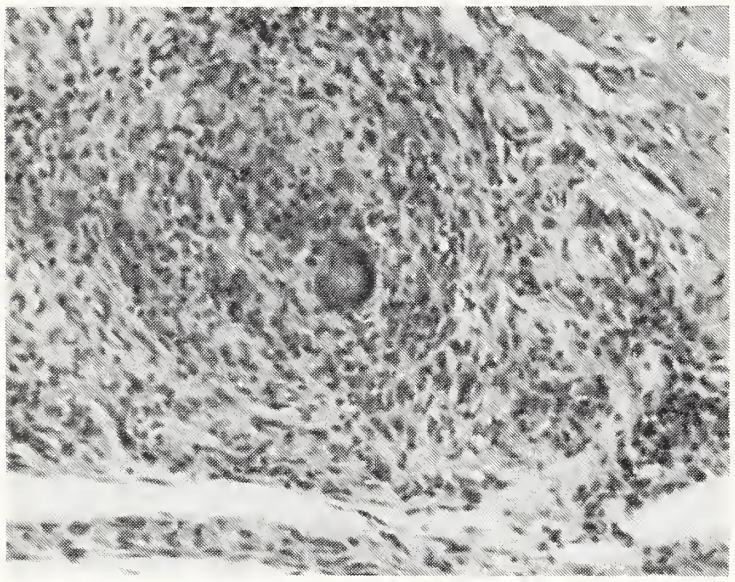


Figure 1. Case No. 4. H & E Stain.

stiffness in this area developed. Over the next three weeks, swelling involving his thumb, palmar space and right wrist was noted. He was treated by a physician with immobilization and Erythromycin, but he did not improve. In November of 1970, he was hospitalized and a synovectomy performed. The microscopic examination of the excised tissue revealed a well-defined granulomatous reaction (See Figures 1 & 2). Acid fast bacilli were present. Cultures, however, were negative at 37°C. He was discharged on bi-weekly streptomycin and ethambutol. Complete healing was noted on a six week check-up. Following application of a PPD intermediate strength, 8 mm. induration was noted.



Figure 2. Case No. 4. 2—Ziehl Neelsen Stain.

DISCUSSION

In each of the above cases, striking similarities were noted. Each patient had been in recent contact with salt water. Too, a definite history of a preceding injury was present. In each case a granulomatous synovitis involving the hand or wrist was present. Although acid fast bacilli were noted on tissue section in two cases. in no case was mycobacteria cultured at 37°C. No evidence of systemic tuberculosis was evident in any case. These factors suggested to us that the offending organism or organisms were acid fast bacilli other than Mycobacterium tuberculosis.

Kelly, et al reported 12 cases of infections involving the tendon sheaths, bursae, joints and soft tissue caused by acid fast bacilli other than M. tuberculosis.[1] In four of their cases, the clinical features were nearly identical with those presented here. The organisms in those cases, although not identified as to species, grew well at 37°C. suggesting that they were not M. marinum.

Aronson first isolated Mycobacterium marinum in fish dying from tuberculosis in 1926.[2] It grew best at 18-20°C. and was pathogenic for mice, goldfish, frogs, and pigeons. Unlike M. tuberculosis, it was not pathogenic for guinea-pigs. Cultural characteristics include moderate growth at 32°C. with production of a yellow pigment similar to that produced by M. kansasii on exposure to light.[3] While Aronson was unable to grow this organism at 37°C., others have accomplished this by repeated subcultures.[4, 5]

Mycobacterium marinum has been identified as producing superficial skin granuloma. Numerous cases of "swimming pool granuloma" or "abrasion granuloma" have been reported.[6–9] In most of these cases, the disease was self limited and responded poorly to INH, PAS, and streptomycin. Gould reported a case of proven M. marinum cutaneous infection of long duration (14 yrs.). This case differed from the others in that laryngeal granuloma were present. Unfortunately, the extracutaneous lesions were not documented by culture.[10] Treatment of this disease is not standardized, however, we felt that some form of chemotherapy was indicated in view of the relapse noted in two of our four cases. Seabury suggested streptomycin and INH, and later ethambutol plus streptomycin, based on experience of cases treated at the Charity Hospital in New Orleans.[11]

In conclusion, we feel that granulomatous tenosynovitis occurring in residents of the Mississippi Gulf Coast should not automatically be considered tuberculous in origin. Physicians should be aware that routine culture at 37°C. may not prove fruitful. We suggest that material be cultured at room temperature, and 32°C. as well as at 37°C. Mice inoculation should also be considered when feasible. Finally, if growth is obtained, an appropriate clinical history should be forwarded along with the specimen to the state laboratory in order to alert them that this organism may be an aquatic pathogen. ★★★

Hospital Drive (39567)

REFERENCES

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TEXAS-SIZE TALE

Alaskans are much less uptight than other folks. In Juneau recently, a steelworker fell five stories and landed with a loud thud on the sidewalk. A cop ran over and asked him what had happened. The guy raised up on one elbow, looked around and said, "Gosh, I don't know, I just got here!"

Qualified Plans as a Tax Shelter for Professional Corporations

JOE MIRSKY, J.D., and
JAMES L. DUNN, A.S.P.A.
Houston, Texas

THE INTERNAL REVENUE SERVICE, setting forth its position in Revenue Ruling 70-101 with respect to the classification of professional service organizations stated that "In the light of recent decisions of the Federal courts, the Service generally will treat organizations of doctors, lawyers, and other professional people organized under state professional acts as corporations for tax purposes." The position of the Internal Revenue has stimulated an increasing trend toward professional incorporation throughout the country.[1] Why? Because, in most instances the true reason for incorporation is to permit the "professional" to avail himself of significant tax advantages as a shareholder-employee of a professional corporate entity, in the same manner and to the same extent, that nonprofessional shareholder-employees have enjoyed these advantages over a long period of time.

A few of the more important tax advantages that should be considered when contemplating the formation of a professional corporation include: death benefits,[2] medical expenses,[3] accident and health insurance,[4] sick pay exemption plans,[5] group term life insurance,[6] pension and profit sharing plans.[7] The most significant of these tax advantages centers around "corporate" pension and profit sharing plans (hereinafter, sometimes referred to as qualified plans). Only four types of qualified plans can qualify under the Code for special tax treatment.[8] These consist of trusteed pension, profit sharing and stock bonus plans,[9] and non-trusteed annuity plans.[10] Accordingly, the scope of this article will be limited to a discussion of qualified plans in general and trusteed (self-administered) plans in particular because of the inherent administrative and investment flexibility available for the shareholder-employee, serving as a co-trustee, in a closely-held corporation.[11]

The authors, an attorney and an actuary, discuss qualified plans as a tax shelter for professional corporations including pension and profit sharing plans and the Internal Revenue Code. They point out that in order to design an effective qualified plan, from a tax standpoint, the professional client should consult a legal practitioner, an actuary and a certified public accountant for guidance as to his individual needs rather than be sold a packaged product by insurance or securities salesmen.

A qualified plan denotes a formal agreement entered into by an employer which contains provisions expressed in a manner which meet the requirements of Section 401 of the Internal Revenue Code of 1954, as amended, (hereinafter referred to as the Code). Evidence that the plan is qualified to receive preferential tax treatment is received by means of an approval letter issued to the employer by the District Director of Internal Revenue.[12] The letter of approval is more commonly referred to as a letter of determination.

Some of the requirements that must be met by a plan to be considered qualified can be stated as follows:

(1) The plan must be in writing.

General Counsel, James L. Dunn and Associates.
Chairman of the corporation.

(2) The benefits and eligibility requirements must not discriminate in favor of officers, shareholders, supervisory employees or highly compensated employees.

(3) The plan must be for the exclusive benefit of employees and their beneficiaries and must be communicated to the employees.

(4) The plan, in its operation, must continue to meet the requirements of Section 401 of the Code.

The implementation and use of both a pension and profit sharing plan will enable an employer-corporation to set aside as much as 25 per cent of its income for its participating employees and obtain an immediate income tax deduction for the amount contributed to the tax exempt pension and profit sharing trusts.[13] The principal and earnings of the trusts are disbursed in later years pursuant to plan provisions relating to retirement, disability, death, severance of employment or termination of the plans.

A pension plan within the meaning of Section 401(a) of the Code is a plan established and maintained by an employer primarily to provide systematically for the payment of definitely determinable benefits to his employees over a period of years, usually for life, after retirement.[14] The determination of the amount of retirement benefits and the contributions to provide such benefits are not dependent upon profits.[15]

A profit sharing plan, on the other hand, may not provide for definitely determinable benefits. It is a plan established and maintained by an employer to provide for the participation in his profits by his employees or their beneficiaries, under a definite predetermined formula for allocating the contributions, made to the plan, among the participants and for distributing the funds accumulated under the plan after a fixed number of years, the attainment of a stated age, or upon the occurrence of an event such as layoff, illness, disability, retirement, death or severance of employment.[16]

Under a pension plan the employee ordinarily receives fixed or determinable benefits by virtue of the fact that the employer contributes to the trust an amount each year estimated to be sufficient to provide those benefits at a future time. In contrast, under a profit sharing plan, the employee receives a portion of profits, computed on an allocation formula set forth in the plan. The allocation formula is usually a percentage of compensation and can be varied each year by the board of directors of the corporate entity. The ability of the directors, by resolution, to vary the percentage of contribution is an important control factor allowing a great deal of flexibility, to wit: in lean years the board of directors, by resolution, could elect to contribute less than the maximum 15 per cent contribution to the profit sharing plan. For example, if the directors elect to contribute only 10 per cent in the current year, in the following year they could elect to contribute the maximum 15 per cent for that year in addition to the five per cent carry-over from the prior year.[17]

The tax effects of a profit sharing plan and a pension plan are very similar in that under both types of plans the employer receives an immediate tax deduction,[18] although the employee pays no tax until he receives his benefits in later years.[19] The earnings of the trust are not taxed to the trust in the interim.[20]

COVERAGE REQUIREMENTS

Only those employees who participate in the trust are considered in determining whether the coverage requirements and the requirements for nondiscrimination in contributions or benefits are met. With respect to coverage of employees participating in either a pension or profit sharing plan, or both as the case may be, if the employees are sufficient numerically to satisfy the percentage requirement[21] or if they constitute a nondiscriminatory classification,[22] the coverage requirements are met.

In determining whether there is discrimination in contributions or benefits in favor of employees who are officers, shareholders, supervisors or highly compensated, only the employees who are included in the trust are considered.

Section 401 of the Code[23] states that if at least 70 per cent of all full time and permanent employees participate in the trust, the requirements are met. The coverage test may also be met if less than 70 per cent of such employees participate in the trust, provided that at least 80 per cent or more of the eligible employees are actually covered by the trust. In determining who are full time and permanent employees there may be excluded those employees whose customary employment is less than 20 hours in any one week, those whose customary employment is for not more than five months in any calendar year and those who have not been employed for a minimum period prescribed by the plan, not exceeding five years.

Where the percentage requirements cannot be met, an alternative is available under Section 401 (a)(3)(B) of the Code, whereby the employer may set up a classification for eligibility provided that such a classification is found by the Internal Revenue Service not to be discriminatory.[24]

A qualified plan must be established and maintained for the exclusive benefit of the employees. Shareholders who are employed by the corporation may participate in a qualified plan provided that the plan is not designed so as to amount to a subterfuge for the distribution of profits to the shareholders.[25] If a qualified plan is not established or maintained for the exclusive benefit of the employees in general it will cease to qualify for special tax treatment.

The trust, being an integral part of the plan, must maintain investment policies which benefit the employees in general. Certain investment requisites with respect to the trust must be met: (1) the cost must not exceed fair market value at the time of purchase; (2) a fair return commensurate with the prevailing rate must be provided; (3) sufficient liquidity must be maintained to permit distributions in accordance with the terms of the plan; and (4) the safeguards and diversity that a prudent investor would adhere to must be present.[26]

VALUATION OF SECURITIES

Furthermore, a qualified pension plan that provides for distributions in accordance with amounts stated or ascertainable must provide for a valuation of securities held by the trust, at least once a year, on a specified inventory date, in accordance with a method consistently followed and uniformly applied.[27] The fair market value on the inventory date is to be used for this purpose and the respective accounts of the participants are to be adjusted in accordance with the valuation.[28] All funds in a qualified profit sharing trust must be allocated to participants in accordance with a definite formula.[29] Hence, no reserves are to be established by withholding allocations from participants. If suspense accounts are maintained, provision is to be made for ascertaining the respective shares of participants in such accounts and such shares are to be included in the distribution.[30]

There are no specific limitations in Section 401 of the Code concerning investments which may be made by the trustees of a trust. Generally speaking, the trustees may use the corporate contributions to purchase any type of investment provided for in the trust agreement to the extent permitted by local law. It should be noted, however, that the trust, otherwise exempt from tax under Section 501, is subject to tax under Section 511 of the Code with respect to any unrelated business taxable income, if any, realized by it from its investments. In addition, the tax exempt status of the trust may be forfeited if the investments made by the trustees constitute a prohibited transaction pursuant to Section 503 of the Code.[31]

ADDITIONAL CONSIDERATIONS

The implementation of a qualified plan implies a permanent as distinguished from a temporary program. Although the employer may reserve the right to change or terminate the plan, or discontinue contributions thereunder, the abandonment of the plan for any reason other than business necessity within a few years after its inception may be evidence that the plan, from its effective date, was not a bona fide program for the exclusive benefit of employees in general. This is particularly true in the case of a pension plan that is abandoned soon after the pensions have been fully funded for employees in whose favor discrimination is prohibited, under Section 401(a), before provision is made for comparable benefits for the other employees.

In the case of a profit sharing plan it is not necessary that the employer contribute every year or that he contribute the same amount or contribute in accordance with the same ratio every year. However, merely making a single or occasional contribution out of profits for employees does not establish a profit sharing plan. There must be recurring and substantial contributions out of profits for the employees.

Contributions under a qualified plan must be made by the corporation, or employees, or both. If all contributions to the trust are made by the corporation the plan is termed a noncontributory plan. In a contributory plan the employees pay for a portion of their benefits and the corporation contributes the balance.

IRREVOCABLE CONTRIBUTIONS

Contributions under a qualified pension or profit sharing plan must be made irrevocably.[32] In the case of a pension plan there is, however, a possibility of a reversion of contributions to the corporation where there has been an actuarial error in computations.[33]

In a trusteed plan the trust instrument must contain a definite and affirmative provision making it impossible, prior to the satisfaction of all liabilities with respect to employees and their beneficiaries under the trust, for any part of the corpus or income to be used for, or diverted to, purposes other than for the exclusive benefit of the employees or their beneficiaries.[34] In order to comply with the foregoing requirement the trust must be evidenced by a written agreement.[35]

A qualified pension plan must provide for a

normal retirement age. This is the lowest age specified in the plan at which the employee has the right to retire without the consent of the employer and receive retirement benefits based on service to the date of retirement at the full rate set forth in the plan. Ordinarily, the normal retirement age under a pension plan is 65, however a different age may be specified under certain conditions.[36] A provision for optional early retirement may be provided in the plan,[37] as well as a provision for continued participation by employees who remain in active service after attaining normal retirement age.[38]

RETIREMENT AGE

There is no normal retirement age in a profit sharing plan. In a profit sharing plan where there is a stated retirement age it is merely one of several events that may be designated as fixing the time for making a distribution.[39] Since the amount of the distribution is dependent upon profits, there is no definitely stated rate of benefits payable at the time of distribution. Hence, the stated retirement age in a profit sharing plan does not have the same significance as "normal retirement age" in a pension plan.[40]

In order to bring into focus the concept of utilizing qualified plans as a tax shelter, pursuant to the foregoing discussion of basic rules governing such plans, an existing one-man professional medical corporation is cited as an example.

Dr. John Doe is President and Chairman of the Board of his corporation as well as a co-trustee of both his pension and profit sharing plans. Dr. Doe has three employees. Dr. Doe and two of his three employees met the minimum age requirement and are therefore covered by both plans. Dr. Doe set his salary at approximately $40,000.00. The two additional employees received a salary of $5,000 and $3,000, respectively.

TOTAL COMPENSATION

Total compensation paid by the professional corporation to all employees including Dr. Doe amounted to $48,000. Since contributions to both plans are based on a percentage of compensation paid to employees, the corporation was able to contribute, and deduct as an expense, a total of $12,000. That is, $7,200 to the profit sharing plan and $4,800 to the pension plan during the first plan year. From a total corporate contribution to the profit sharing plan of $7,200, Dr. Doe received $6,000 of credit to his account in the plan. From a total corporate contribution to the pension plan of $4,800, Dr. Doe received $4,000 of credit to his account in that plan.

CONCLUSION

The key to designing an effective qualified plan, from a tax standpoint, is the implementation of a formula which produces the best combination of benefits without running afoul of the statutory qualification criteria.[41] The "professional" client, seeking to obtain the benefits discussed in this article, must turn to the legal practitioner, consulting actuary and certified public accountant for advice and guidance in the design of a plan best suited to corporate and individual needs; rather than be sold a "packaged product" by insurance or securities salesmen.

The funding "medium" or "method" that should be used by the corporation for a qualified plan is a trust fund,[42] as opposed to a funding method utilizing insurance contracts. The authors of this article feel that the flexibility available in a trusteed plan offers a distinct advantage with respect to equity or real estate investments in any pension or profit sharing trust fund. The exact amount of such investment will be determined by objectives, liquidity demands and other considerations. Only through equity and/or real estate investments can an employer hedge against rising pension costs which have been experienced in the past and may be anticipated in the future due to the inflationary trend of our economy. Those who agree with this principle will adopt their funding medium with this point in mind.

In conclusion, it should be noted that the actuary is an architect in the field of qualified plans. The actuary designs the plan, determines its cost, and sees to it that it is put into operation effectively. In carrying out his functions the actuary is confronted with many problems which require solutions by experts in other fields, namely, attorneys and certified public accountants. Some of the activities of the actuary, attorney and accountant overlap and it is only with the combined efforts of each, in a team approach, that a qualified plan can be effectively designed for the professional corporation. ★★★

1420 Americana Building (77002)

REFERENCES

1. The Mississippi Legislature, by virtue of H.B. 48, Laws 1970, approved and effective March, 1970, amending the existing "Mississippi Professional Corporation," has sanctioned the incorporation of physicians, surgeons and attorneys at law. Prior to this amendment, incorporation of professional services in the aforementioned categories was proscribed.
2. Internal Revenue Code of 1954, Section 101(b).
3. Ibid, Sections 105(b) and 213(a).
4. Ibid, Sections 104-106.
5. Ibid, Section 105(d).

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6. Ibid, Section 79.
7. Ibid, Sections 401-404 and 501.
8. Ibid, Section 401(a), 403(a).
9. Ibid, Section 402(a), 404(a)(1), 404(a)(3), 2039(c)(1), 2517(a)(1).
10. Ibid, Sections 101(b)(2)(B)(ii), 403(a), 404(a)(2), 2039(c)(2), and 2517(a)(2).
11. A brief discussion favoring trusteed plans as opposed to insurance funded plans is set forth at the conclusion of this article.
12. See, Revenue Procedure 69-4 and Revenue Procedure 70-9 modifying Revenue Procedure 69-4.
13. I.R.C., Section 404(a)(7).
14. Income Tax Regulations, Section 1.401-1(b)(1)(i). Note: The term "definitely determinable benefits" refers to retirement benefits arrived at by means of actuarial assumptions that are generally based on such factors as years of service, compensation and the age of the employee.
15. Ibid.
16. Reg. Section 1.401-1(b)(1)(ii).
17. The determination by the board of directors as to what percentage of "profits" shall be contributed to the profit sharing plan is usually made at the end of the taxable year when the accountant has rendered his figures with respect to receipts and disbursements.
18. I.R.C. Section 404(a)(1) and (3).
19. Ibid, Section 402 as amended by the Tax Reform Act of 1969.
20. Ibid, Section 501.
21. Ibid, Section 401(a)(3)(A), 401(a)(4).
22. Ibid, Section 401(a)(3)(B), 401(a)(4).
23. *Supra,* note 21.
24. The leading case, with respect to a classification set up by an employer, is *Pepsi-Cola Niagara Bottling Corp.,* 339 F. 2d 390 (CA-2, 1968). See also, Rev. Rul. 70-200, where a salaried-only profit sharing plan, under which 22 of 40 participants are officers, shareholders, or supervisors, met the coverage requirements of Section 401(a)(3)(B) of the Code.
25. Reg. 1.401-1(b)(3).
26. Rev. Rul. 69-421, Part 2(k).
27. Ibid, Part 2(s).
28. Ibid.
29. Reg. 1.401-1(b)(1)(ii).
30. Rev. Rul. 69-421, Part 2(t).
31. I.R.C. Section 503(b), lists six types of prohibited transactions which, if engaged in by the trustees with the employer-grantor, or related or controlled interests, may bring about a loss of the trust's tax exempt status.
32. I.R.C. Section 401(a)(2).
33. The only other instance where contributions may revert to the corporation, in the case of either a pension or profit sharing plan, is where the trust instrument specifically provides for such reversion in in the event that the District Director refuses to issue a favorable letter of determination.
34. I.R.C. Section 401(a)(2); Reg. Section 1.401-1(a)-(3)(iv).
35. Rev. Rul. 69-421, Part 3(a).
36. Ibid, Part 5(e).
37. Ibid, Part 5(f).
38. Ibid, Part 5(g).
39. Provision must be made for allocating contributions among participants and for distributing the accumulated funds after (1) a fixed number of years, (2) the attainment of a stated age, or (3) upon the occurrence of some event such as layoff, illness, disability, retirement, death or severance of employment.
40. Rev. Rul. 69-421, Part 5(e).
41. I.R.C. Section 401 et seq.
42. Under a fully trusteed plan the employer makes deposits to a trust fund based upon: (1) an actuarial valuation of the plan's assets and liabilities, performed by an independent actuary in the case of a pension plan, (2) in the case of a profit sharing plan, deposits are made to a trust fund pursuant to a predetermined formula for allocating contributions. The trust fund is then invested by the trustee or co-trustees pursuant to investment powers set forth in the trust agreement between the employer-corporation and the trustees.

WHO NEEDS IT?

Although the waiting father was anxious to see his newborn son, he never once asked me about the mother. When I questioned him about this, he said, "Well, to tell you the truth, Doc, my wife and I haven't spoken to each other for over a year."

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Nov. 28-Dec. 1, 1971, New Orleans, Annual Convention, June 18-22, 1972, San Francisco. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

STATE AND LOCAL

Mississippi State Medical Association, 104th Annual Session, May 8-11, 1972, Biloxi. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Joel L. Alvis, 714 N. State St., Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Second Wednesday, April and First Wednesday, November, 2:00 p.m., Clarksdale. Glenn L. Wegener, 1967 Hospital Drive, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. John G. Downer, 110 Tchula St., Lexington, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. A. Robert Dill, 1001 Main Street, Columbus, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Robert Donald, Box 1351, Pascagoula, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb. Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie Street, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday, January, April, July, and October, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.



The President Speaking

'Rights, Responsibilities, and Logic'

ARTHUR E. BROWN, M.D.
Columbus, Mississippi

WITHIN THE LAST few years when anyone desires something and his demands are questioned, he shouts that his "rights" are being violated. Agitators seize upon key phrases that are emotional rather than factual in their appeal. One that physicians hear the most often is that the "right to medical care" is being denied certain groups.

It was my privilege to attend the AMA convention in Atlantic City and while there I sat with some members of the Los Angeles County Medical Association. I found that they had formed a special committee on health care to define what these "rights" really were.

"A right is something that one may properly claim as his due by law or self imposed. It stems from the established custom of society or from the law. It cannot be presumed by an individual, on his sole declaration without a basis in custom or in law."

Medical care is truly a basic need and it is the right of every citizen to have access to adequate medical care, but it is his responsibility to seek it. Health care is an inclusive term and includes sanitation, nutrition, housing, hospitalization and rehabilitation. Medical care is the responsibility of the physician but the other factors of health care are the responsibilities of society at large.

Physicians have often been accused of negligence for deficiencies in health care and for excessive costs over which they have no control. With all of the present and proposed legislation facing us today, we as physicians should be greatly concerned about welfare, medical and health care costs. It is time to assert that we, too, have "certain unalienable rights."

The above is the position and policy of the Los Angeles County Medical Association. It sounds logical and fair and if followed generally, may serve to bring about some order to the chaotic thinking of the planners concerning the delivery of medical care.

★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 9
SEPTEMBER 1971

EDITORIALS

Killer Twisters: Challenge to Emergency Medical Services

I

TORNADO!

This awesome phenomenon of nature's wrath packs the destruction of a nuclear bomb, a swiftness second only to lightning, and a killing capacity almost invulnerable to active and passive defense. The worst hurricane to hit the North American continent in meterological history, Camille in 1969, was only half as wasteful of human life as at least two tornadoes recorded in Mississippi: Natchez with 317 deaths on May 7, 1840, and the dreadful Tupelo disaster of the 1930's.

Tornadoes make medical emergencies of unprecedented proportion, made all the worse by utter destruction where the injuries and deaths occur. But unless spawned out of a widespread storm or hurricane system, tornado destruction tends to be self-isolating, leaving adjacent communications and facilities relatively untouched. On the other hand, casualties from tornadoes are concentrated into small areas, and resulting need for medical service will more than likely exceed the area's capacity to supply it, even when hospitals survive destruction.

Mid-America's tornado alley is the Mississippi River Valley and immediately adjacent watershed areas, and the Deep Gulf South is especially vulnerable to these fearful, little-understood whirl winds of exceptional violence. The National Weather Service of the National Oceanic and Atmospheric Administration reports that during the past 18 years, Mississippi has been hit on the average with 17 tornadoes annually. The chances of tornado death and injury in our state exists in 14 of these storms each year. So even if the sun is shining today, we'll be confronted with an urgent need for emergency medical services in tomorrow's tornado.

II

Twenty-seven tornadoes raked 23 Mississippi counties during 1970. They occurred over a span of 10 months on 16 days, causing four deaths, 107 injuries, and an estimated $2.9 million in property damage. All of the deaths and 88 of the injuries occurred in April.

But 1970 was an unusually light year for the killer funnels, especially if contrasted to 1966 when in seven months, 30 twisters ripped the state, killing 58 persons and injuring 532. Most of this devastation took place in the Candlestick Park disaster at Jackson on March 3 when 57 died and 504 were injured. Property damage in an area of just two square miles amounted to $18 million, when a western shopping center was hit in late afternoon.

February, March, and April are the worst months for tornadoes in Mississippi, according to the National Weather Service. But, the meteorologists caution, the only thing consistent about tornadoes is their totally unpredictable and er-

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ratic behavior. They can and do occur on any day in any month of the year, although historically, at least two months out of each year are free of the storms, and most will occur in a span of five months from late winter through the spring into early summer. Late afternoon through early evening is the prime danger period.

Oddly enough, there is almost a cyclic pattern in tornado intensity. No deaths from the killer twisters were reported in Mississippi during a third of the 18 years studied by the National Weather Service, and they were in pairs back to back: 1954-55, 1960-61, and 1964-65. The turnabout came in 1966 with the modern record for death and injury. But the experience record produces a gloomy first in that Mississippi has sustained more persons killed by tornadoes per 10,000 square miles than any state in the Gulf South.

III

The tradition of service in disaster is a proud one in Mississippi for physicians, hospitals, and allied professional personnel. Never in time of need has there been any lack of willing and dedicated members of the health care team, although in all honesty, it is a matter of individual response rather than by preplanned design.

There is no master plan for emergency medical services in time of disaster in the state. Which is to say, before somebody points to his hospital's or city's emergency service plan, that there is no coordinated, inclusive, regularly maintained and rehearsed medical service plan on a statewide basis.

Most component medical societies are organized to furnish physicians' services, and virtually every hospital has a working plan for instant mobilization for local disaster situations. The Mississippi Hospital Association is far and away the best prepared major member of the health care team for service in disaster. MHA's interinstitution radio network has proved its value time and time again, especially in the destructive rash of tornadoes in the Delta on Feb. 21, 1971.

The Mississippi State Medical Association possesses the capacity to mobilize quickly, and the 1969 Hurricane Camille tragedy was such an example. But the association has no coordinated and continuing program for this service, and it is dependent upon the telephone and somebody else's radios for communications. The need for a master program is clear, because coordinating agencies, both public and private, occasionally permit emotion to distort judgment in time of disaster.

A prime example was the call for physicians on the Gulf Coast the day after Camille. Teams were hastily organized, and emergency transportation procured. Once there, the doctors found that they were not needed, and their presence merely contributed to already intolerable problems in drinking water and food supplies as well as housing and sanitation. In the same disaster, a private organization charged with transportation of litter cases had one ambulance at the Gulfport airport for a planeload of 47 injured elderly persons. The snafus are bound to happen, but a coordinated plan can hold them to a minimum.

IV

Almost everybody has something to contribute in disaster relief and service. But the nature of a tornado being what it is, the plan has got to be push button certain to be of value. This implies a need for excess capacity just to be sure of having enough when it is needed most.

There are all sorts of formulas for emergency medical services, and they usually revolve around the community hospital. The team format is popular, assigning small groups certain tasks with each possessing full capabilities in a given field, such as surgery, triage duty, and the like. While



"You're anemic, Snow White."

the local plan is of paramount importance—for local is what a tornado is—there still is urgent need for statewide coordination, a reliable mobilization plan, communications not dependent upon vulnerable static utilities, and sufficient supplies.

The hospital association has clearly shown the way with its radio network. The strategically located, trained, and well-equipped National Guard also plays a major role in rendering service in disaster, and it too has flexible communications. The problem comes down to the fact that institutional communication and action works much better than does the organization of individuals in an emergency. The invarible effectiveness of physicians comes much more from training, discipline, and dedication than from machine-like organization, and doctors have not failed in time of disaster in the state.

The tornado is about the best example of our frailty before nature's destructive forces and the best reason we could have for critically reassessing our emergency medical service capabilities. Tomorrow may bring a challenge we cannot meet. —R.B.K.

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New Routes for FMG's to USA M.D.'s

The roadblocks to first class medical citizenship are coming down under a brand new policy of the AMA Council on Medical Education. The liberalization of the tough restrictions for approved postgraduate training in internships and residencies will assist both foreign nationals and American citizens among foreign medical graduates.

Without a doubt, the pitiable plight of American medical students in foreign schools, especially in Mexico, exerted influence on the decision. The shortage of physicians, too, had obviously become a consideration, what with the large numbers of FMG's now filling vacancies in residency programs.

As of July 1, five avenues exist by which foreign medical students or graduates may enter American medical education programs. One is particularly innovative, exactly fitting the circumstance of most American citizens training in foreign schools. They are:

—Admission from a foreign medical school to an American school with advanced standing. The program is called COTRANS, coordinated transfer system, and it is jointly sponsored by the Association of American Medical Colleges and the National Board of Medical Examiners. It assists American students in foreign schools with their applications for acceptance in the United States.

—Certification by the Educational Council for Foreign Medical Graduates on the basis of satisfying requirements and passing the ECFMG examination.

—Obtaining a full and unrestricted license to practice medicine issued by a state or other U. S. jurisdiction authorized to license physicians. This, however, is not always easily accomplished.

—Successfully passing the complete licensure examination in any state or other U. S. licensing jurisdiction in which law provides that a full and unrestricted license to practice will be issued after the satisfactory completion of internship or residency training in that state without further examination. And to be eligible for this route, the FMG must also have passed the ECFMG examination. Also not an easy trick.

—And the new one, just for U. S. citizens, permits admission to AMA-approved residency programs when the student from the foreign medical school (1) completed his premedical training in an approved U. S. college or university of a quality acceptable for matriculation in a U. S. medical school, (2) studied medicine at a school outside the United States, Puerto Rico, and Canada which is recognized by the World Health Organization, and (3) completed all of the formal requirements

of the foreign medical school except internship and/or social service.

The latter has been a bar to receiving the foreign M.D. degree and, hence, a simultaneous bar to entry into a residency program in the United States. In Mexico, for example, medical students must undergo a year of internship and a year of social service to qualify for award of the undifferentiated M.D. degree. The new pathway trims the time by two years, assuring entry into a training program and recognition as a doctor of medicine.

Heretofore, the premedical training was not considered in educational equivalency for FMG's. So the new policy takes into consideration the value of a quantity which may have been too long overlooked. The matter of limited institutional licensure for FMG's remains in the hands of the states, ranging from the rigid requirement of Mississippi's new law enacted this year with multilevel approval to the more liberal laws in some other states where only the licensure agency makes the determination.

The connotation is one of recognizing quality previously removed from consideration; it is not a policy of making first class medical citizens out of second class doctors, because in no instance may the FMG qualify when he is unprepared. And it all proves that the medical establishment is neither hidebound nor reactionary but that it is more than ever geared to the times and attuned to need.—R.B.K.

GI Addicts and the Assault on Drugs

The armed forces have taken the battle initiative in a frontal assault on drug abuse. From Vietnam to stateside boot camp, military authorities are clamping down, but the program isn't all that punitive. Even the hard user who has become addicted still has a say-so about his treatment regimen.

Testifying before a senate subcommittee, Deputy Defense Secretary David Packard said that he doesn't give much credence to the recently discovered narcotic addiction rate of 2 per cent in Vietnam. He thinks it may be even less. The unusual aspect of this assertion is two-fold: Most observers have estimated the addition rate as being between 10 and 15 per cent among American forces in Southeast Asia and second, Secretary Packard's statement was the first time a Pentagon representative had given a firm figure.

Dr. Richard Wilbur, newly appointed Assistant Secretary of Defense for Health and former Deputy Executive Vice President of AMA, told the Senate Armed Services Committee at his confirmation hearing that drug abuse among U. S. servicemen was his number one priority. All services have initiated voluntary treatment programs for service members, and except for the Navy and traditionally tough Marine Corps, they are totally nonpunitive.

Army and Air Force personnel returning home from Vietnam make a mandatory stop for urinalysis screening. The tricky tests detect heroin users, but Secretary Packard warned that the tests are not infallible. Frankly negative findings speed the homeward bound service member to the U.S.A., but positives are detoured to detoxification centers.

After four days in isolation, servicemen are retested at the centers. Negatives are released, but positives, especially those exhibiting withdrawal symptoms, are air evacuated to a treatment center in the United States. There, they may elect to undergo psychiatric evaluation and regimens up to 56 days of inpatient care. If they say that rehabilitation treatment is not their cup of tea, they are discharged and referred to the Veterans Administration.

Most servicemen found to be using hard drugs are experimenters rather than hard users, the military medical authorities report. Thus it follows that the programs may be effective in catching the user early enough. Let it be earnestly hoped that this is a measure in time and a lessening of the scars left by the war.—R.B.K.



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"Congratulations, Mr. Slumgully, one of the medical journals has just picked yours as the 'Disease of the month'!"

VS: Shift in Social Attitudes

It may be controversial, but there's no denying that voluntary sterilization is gaining in popularity as a birth control measure in the United States. Beating the drum for VS, as voluntary sterilization is abbreviated in the vernacular, is the Association for Voluntary Sterilization, also a growing movement nationally.

AVS has released studies of 509 association-assisted cases in 1969, and the findings are unusually interesting. Four out of five voluntarily sterilized individuals were male, but the youngest case was a 19-year-old female who had delivered three living children. The youngest male was a father of three who had to wait until his 21st birthday so that he might give legal consent for vasectomy.

Two out of three sterilized were under age 40, and most had three or more living children. Educational backgrounds of patients varied, but four out of 10 had some university or college training, and only one out of four failed to complete high school.

The studies by AVS tend to demonstrate that sterilization isn't the procedure for the poor, as is sometimes alleged. Only 6.4 per cent of the patients in the AVS sample were receiving welfare benefits when they were operated on, while a whopping 47 per cent were receiving $10,000 per year or more in earned income. The sample represents patients in 34 states and the District of Columbia, and only 10 per cent said, in giving histories, that the procedure was desired because of medical or psychiatric reasons. Most simply wanted to limit the size of their respective families.

AVS said that in 34 per cent of the cases, either the patient or the spouse was Roman Catholic.

The report stated that Blue plans in 41 states will pay for sterilization procedures on a basis of medical necessity, and 36 of these also make payment when the operation is done for socioeconomic reasons. CHAMPUS pays for sterilization under the aegis of family planning, but vasectomy benefits are limited to the retired military since the program does not cover a service member on active duty. Forty-three Medicaid programs in as many states were reported as paying for sterilization.

AVS contends that more than 2 million American adults have had the procedure and that the rate is now about 200,000 annually and growing. The inferences drawn from the report cannot be viewed as conclusive of social and medical practice trends for two principal reasons: The study sponsor, in all fairness, is the advocate of the findings and second, the sample is neither scientific nor sufficient. But it does seem indicative of a shift in social attitude which could become a form of culture policy within a decade.—R.B.K.

Ping Pong, Diplomacy, and Physical Conditioning

Now that ping pong has become the sport of diplomacy, the game is getting all sorts of boosts, including a good word from the medical profession. Dr. Andreas Gal of New York says that table tennis is one of the best forms of exercise for persons of all ages and that "no sport is safer."

We'd be inclined to agree on the safety aspects, because nowhere in the mortality tables or among the grim and gristly vital statistics do we discover data on head injury from getting beaned by a ping pong ball.

Dr. Gal may not be wholly objective in his enthusiasm, because he has twice been the U. S. Table Tennis Open Champion. But enthusiastic he is, stating that "table tennis is a great conditioner and an excellent means of relieving tension." It must be assumed that he is not punning on the craft of diplomacy.

The New York physician says that table tennis has an important role in rehabilitation and is invaluable as recreational therapy for the physically handicapped and the mentally ill. The game is credited with development of neuromuscular skills and muscle endurance. Dr. Gal says that cardiorespirator benefits also ensue.

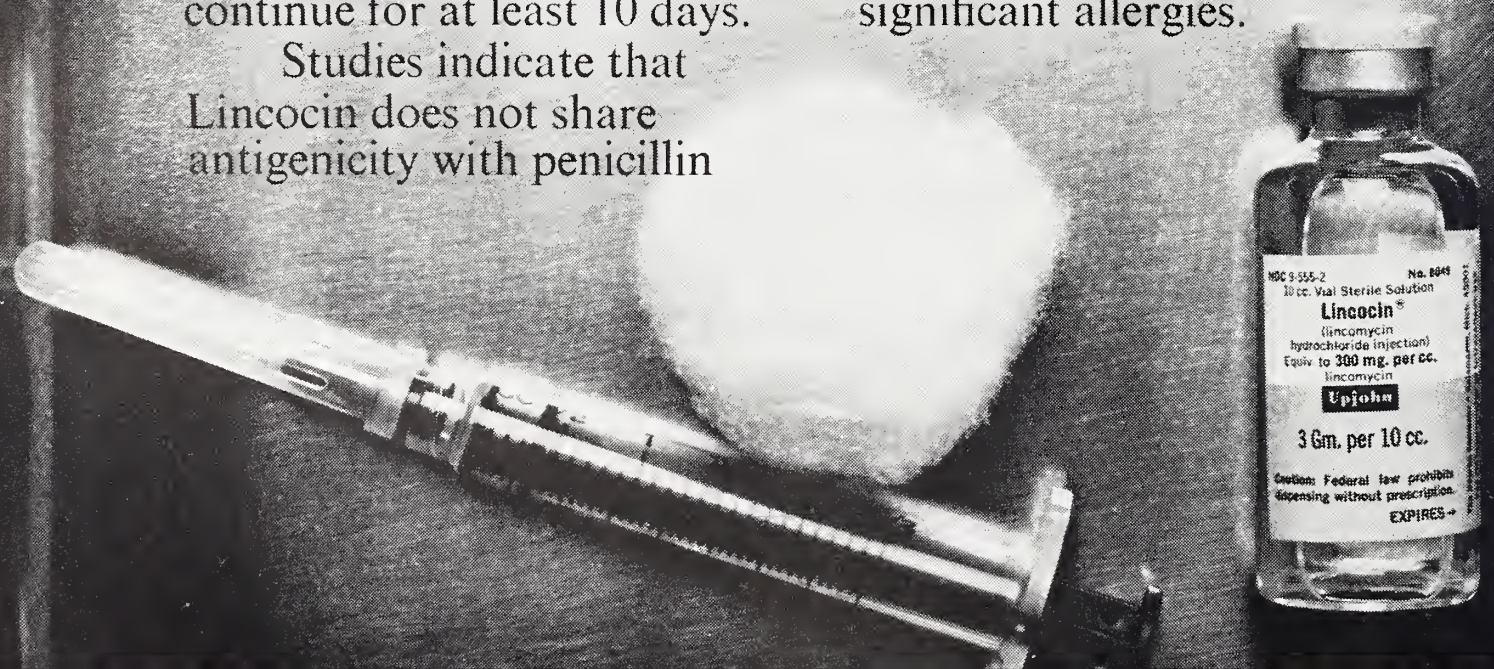
The idea, Dr. Gal continues, is the more you play, the better you get, and the better you get, the more you play. All of which, he says, means more exercise leading to better physical conditioning. Ping pong helps to gain proficiency in other sports, too, the physician champion observes, noting that some pro football coaches require players to get in off-hours table tennis to hone response and reaction time. A full match is the rough equivalent of a three mile track event, Dr. Gal says.

With all deference to the physical, medical, and other assorted benefits of table tennis, it is a little disconcerting to think that 750 million Chinese are all that good, conditioned, and honed up. We anxiously await the findings on pool shooting.—R.B.K.

Hypersensitivity to penicillin is a good reason to consider Lincocin®
(lincomycin hydrochloride)

Lincocin (lincomycin hydrochloride, Upjohn) has produced a high percentage of satisfactory responses in patients with mild, moderate and severe infections due to susceptible streptococci, pneumococci and staphylococci (including many penicillinase-producing strains). With β-hemolytic streptococcal infections, treatment should continue for at least 10 days.

Studies indicate that Lincocin does not share antigenicity with penicillin compounds. However, hypersensitivity reactions such as angioneurotic edema, serum sickness and anaphylaxis have been reported, some of these in patients known to be sensitive to penicillin. As with any antibiotic, Lincocin (lincomycin hydrochloride, Upjohn) should be used cautiously in patients with histories of asthma or other significant allergies.



Book Reviews

The Secretory Immunologic System. Edited by Drs. Delbert H. Dayton, Jr., Parker A. Small, Jr., Robert M. Chanock, Herbert E. Kaufman, and Thomas B. Tomasi, Jr. 544 pages with illustrations. Bethesda, Md.: U. S. Government Printing Office, 1971. $5.25.

This monograph is the result of a conference, fifth in a series, sponsored by the National Institute of Child Health and Human Development. Bringing together biologists of widely different views and areas of investigation, the stated purpose is to explore and extend current knowledge of the many factors operative in human resistance to disease.

This particular volume deals with the relatively new field of research concerned with regional immunity mediated by locally formed antibody. In itself, the concept is not new. However, new stature is being added through recent and current research which demonstrates the presence in secretions of locally produced immune globulin (IgA). This fraction has been shown to be distinct from the serum component and is independent of cellular resistance. It is the dominant antibody in all external secretions. However, it is but a part of the local defense mechanism and relatively little is known of its biologic activity.

Secretory immunoglobulins are believed to play an important role in allergic reactions, defense against potentially pathogenic organisms, immunologic deficiency diseases, as well as prophylactic immunization. The text demonstrates what work still needs to be done in order to establish the secretory system as an operative protective mechanism. There is much yet to be learned of other immunologic systems and non-specific mechanisms in host defense. As yet, the secretory, humoral and cellular systems are inadequately related in terms of overall knowledge of immunologic defenses. This volume is the first multi-disciplinary publication devoted exclusively to the secretory immunologic system and will be a useful reference volume on the subject.

DURWARD L. BLAKEY, M.D.

Guides to the Evaluation of Permanent Impairment. Edited by the AMA Committee on Rating of Mental and Physical Impairment. 164 pages. Chicago: American Medical Association, 1971. $5.00.

The evaluation of impairments requires some base lines upon which to depend so that the findings can be reproduced by others who may also objectively examine the subject. This book is a compilation of revised "Guides" which have been produced by the ad hoc Committee on Medical Rating of Physical Impairment of the American Medical Association and published separately in the *Journal of the American Medical Association*. The committee members and consultants who produced this material are well qualified in their respective fields.

The format is easily understood if studied. The subject areas covered are: the extremities and back; the peripheral spinal nerves; the central nervous system; the respiratory system; the cardiovascular system; the hematopoietic system; ear, nose, throat and related structures; the digestive system; the reproductive and urinary systems; the skin; mental illness.

I cannot evaluate all of the material, but since the section on extremities and back was produced in 1958. I have frequently referred to the "Guide" and have found it very useful. However, it must be remembered that evaluation of the back and extremities is not complete if limited to range of motion as seems to be advocated by this guide. Correlation with vascular, neurological and mental status is necessary for thorough and complete survey.

This is a reference book which the practitioner in any field should find helpful, a very desirable adjunct to be kept near at hand.

GEORGE D. PURVIS, M.D.

Miami Presents Course in Otolaryngology

A postgraduate course in otolaryngology for the family physician will be presented by the department of otolaryngology at the University of Miami School of Medicine Oct. 8-9, 1971 at the Sheraton Four Ambassadors Hotel in Miami.

The postgraduate education course will be ac-

ceptable for nine hours of American Academy of Family Practice credit.

For further information, write: Dr. F. W. Pullen, II, M.D., Neuro-Otologic Laboratory, School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

DEATHS

BREVARD, LEON HAWKINS, Marks. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1907; postgraduate, Tulane University School of Medicine; member of Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; died June 24, 1971, age 90.

HILL, FRANK SMALL, Greenwood. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1912; interned Bellevue Hospital, New York City, one year; Children's Hospital, New York, one year; presented Golden "T" by University of Tennessee, 1962; member of Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; died June 26, 1971, age 83.

ROBINSON, ROLLO HERSCHELL, New Albany. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1964; interned St. Francis Hospital, Wichita, Kansas, one year; died July 26, 1971, age 33.

SAFLEY, JAMES EDWARD, Brookhaven. M.D., Tulane University School of Medicine, New Orleans, La., 1948; interned Charity Hospital, New Orleans, La., 1948-49; ob-gyn residency, same, 1949-1952; died July 11, 1971, age 54.

SMITH, ARTHUR HENRY, Sumner. M.D., Illinois Medical College, Chicago, Ill., 1909; interned Bellevue Hospital, New York City, two years; member of Fifty Year Club of MSMA; died July 3, 1971, age 85.

WALKER, BEN N., SR., Madison. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1915; interned Charity Hospital, New Orleans, La., one year; Emeritus member of MSMA and AMA; died July 1, 1971, age 85.

WEEKS, JAMES THOMAS, Mt. Olive. M.D., Memphis Hospital Medical College, Memphis, Tenn., 1912; interned four months, 1934, Tulane; vice-president of MSMA, 1942; member of Fifty Year Club of MSMA; died June 27, 1971, age 86.

PERSONALS

FRANK R. BANKS has associated with the Ball-Pittman Clinic for Women for the practice of obstetrics and gynecology at 1820 Hospital Drive in Jackson.

DAVID BALL of Batesville has been named Panola County chairman of the 1971 campaign to fight children's lung diseases by leaders of the Mississippi chapter of the National Cystic Fibrosis Research Foundation.

WILLIAM L. BASS has announced the opening of his office for the practice of general psychiatry at 4500 West Pass Road in Gulfport.

LOUIS A. BENOIST announces the opening of his office for the general practice of medicine at 453 John R. Junkin Drive in Natchez. He will be associated with J. L. HENDERSON.

HELEN C. BERNFIELD of Jackson was the Jackson Altrusa Club delegate to the International Altrusa Convention held recently in San Francisco.

JOEL TRAVIS CALLAHAN announces the opening of his office for the practice of internal medicine and gastroenterology at 1108 21st Avenue in Meridian.

TOM CAREY has opened an office in the Plaza Shopping Center in McComb. Dr. Carey limits his practice to diseases of infants and children.

A. ROBERT DILL of Columbus presented an instructional program on artificial respiration and circulation to members of the Pilot Club of West Point at their monthly meeting.

CHARLIE ELLIOTT has associated with O. P. STONE and LOWELL KETCHUM in the practice of medicine at Ripley.

JOHN E. EVANS has associated with the Vicksburg Clinic in the department of orthopedic surgery.

S. R. EVANS, JR. has opened his office at Suite 503 in the Medical Arts Building in Jackson for the practice of surgery and oncology.

JOSEPH GRIFFING of Picayune has been appointed clinical assistant professor of radiology at Tulane Medical School in New Orleans. Dr. Griffing

will continue his practice in Picayune but will devote part time to medical student teaching.

VAN DYKE HAGAMAN and RAYMOND S. MARTIN, JR., of Jackson were recognized in special ceremonies for a combined service of 50 years with Rehabilitation, Division for the Blind.

NANCY A. JAMCHUK and ANTONIO JAMCHUK announce the opening of their offices at 200 South Chestnut Street in Aberdeen.

JOHN R. HARPER has associated with ROBERT E. JENNINGS of Taylorsville for the practice of general medicine.

M. E. HINMAN of Vicksburg has been elected president of the Mississippi Historic Foundation.

THOMAS R. SINGLEY has associated with JACK C. HOOVER of Pascagoula for the practice of obstetrics, gynecology and infertility at Bel Air Shopping Center.

WHITMAN B. JOHNSON, JR., of Clarksdale has purchased the former Clarksdale Hospital and is renovating it to accommodate his offices.

CHARLES R. MCCOLLUM, JR., announces the opening of his office for the practice of internal medicine and gastroenterology at Suite 262, Hinds Professional Building, 1815 Hospital Drive in Jackson.

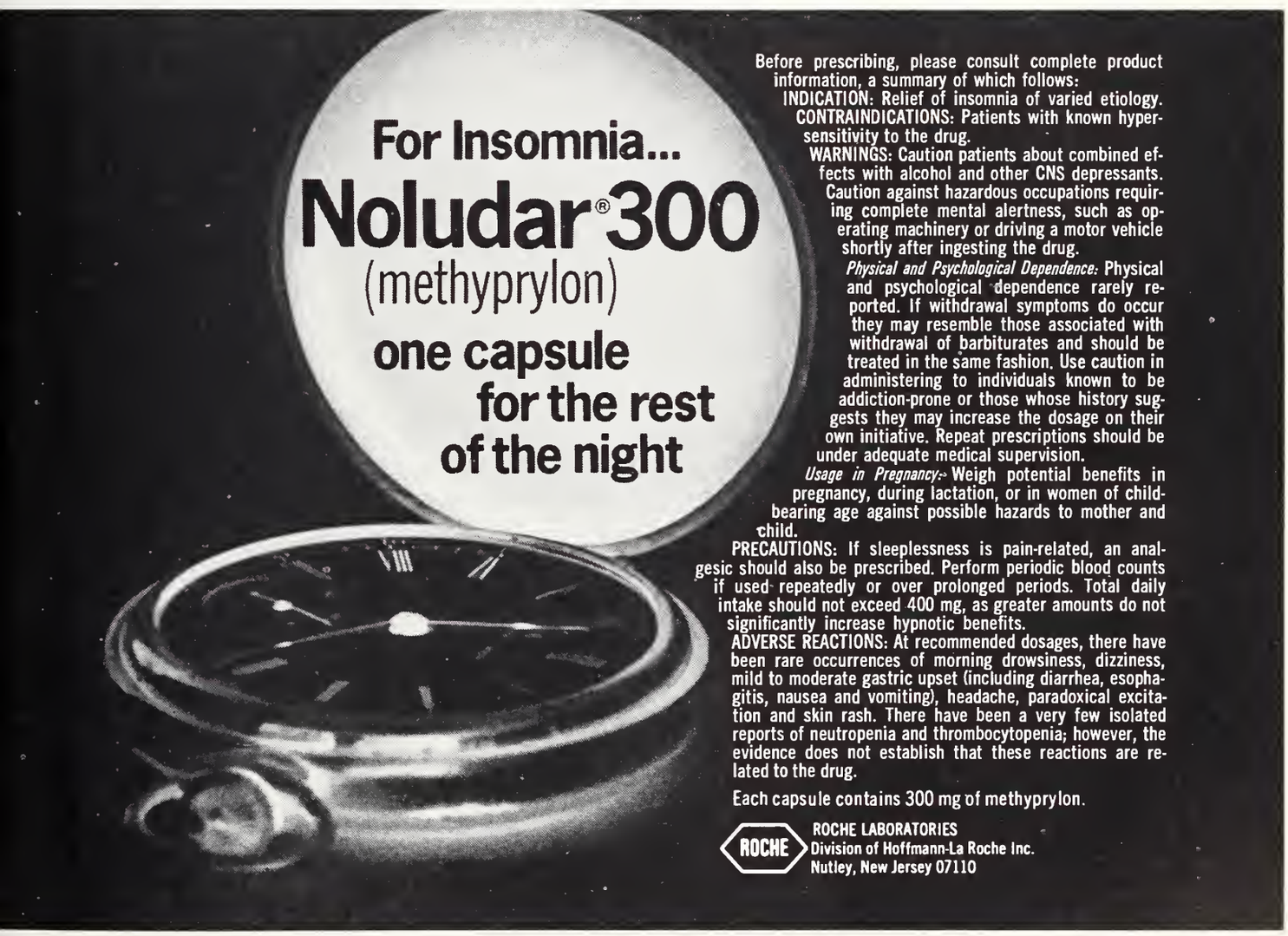
JAMES H. MCGEE, formerly of Atlanta, is the new director of the Forrest, Jones, Perry and Covington county health departments. His headquarters are in Hattiesburg.

WILSON E. MOAK announces the opening of his offices for the practice of ophthalmology in the Lakeland Eye Clinic at 882 Lakeland Drive in Jackson.

J. D. MORGAN announces the opening of his new offices for the practice of internal medicine at 622 Delaware Avenue in McComb.

TOXEY M. MORRIS has associated with JACK D. DANIEL and RICHARD A. JOHNSON of Hattiesburg in the practice of urology and urological surgery at 2802 Mamie Street.

WILLIAM E. NOBLIN, III, announces the opening of his office for the practice of plastic surgery at



500 J East Woodrow Wilson Drive in Jackson.

F. J. SELMAN, JR., has associated with ROBERT F. CARTER, JR. for the practice of urology at 964 West Division Street in Biloxi. Dr. Carter also has offices in Pascagoula.

JAMES E. SPENCE has joined the staff of the Hattiesburg Clinic P.A. for the practice of internal medicine and gastroenterology at 415 South 28th Avenue.

W. GRANVILLE TABB, JR., announces the opening of his office for the practice of ophthalmology at 653 North State Street in Jackson.

J. E. VARNER, JR., has associated with J. P. CULPEPPER, JR., of Hattiesburg in the practice of surgery at 709 Arledge Street. Dr. Varner has recently finished his surgery residency at the University of Mississippi Medical Center in Jackson.

WILLIAM M. WOOD of Meridian was featured guest speaker at the July meeting of the Southwest General Hospital Medical Staff. Dr. Wood, a psychiatrist, is administrator of the Weems Community Mental Health Center in Meridian.

POSTGRADUATE CALENDAR

POSTGRADUATE INSTITUTE

Enrollment in the Mississippi Postgraduate Institute in the Medical Sciences four-year program for family physicians will be increased by a limited number of new registrants in 1971. Supported by the Mississippi Regional Medical Program, the Institute combines attendance at intensive five-day workshops at the University Medical Center with participation in elective seminars and scientific sessions. Registration in the one-week courses is limited to Institute enrollees.

CIRCUIT COURSES

Dates and places for the 1971-1972 Circuit Courses will be announced in the October issue of the JOURNAL MSMA.

ALLIED HEALTH PROGRAMS

Physicians are invited to call attention of nurses in their communities to the Cardiac Nursing Seminar to be held October 21-22 at the University Medical Center under Mississippi Heart Association auspices, and to a resumed series of one-month courses in coronary care unit nursing. First session of the Mississippi Regional Medical Program CCU courses will be held in September with others slated for November, January and March.

ADVANCE CALENDAR

EKG ONE-WEEK COURSE, October 3-8, 1971

PEDIATRICS ONE-WEEK COURSE, October 18-22, 1971

SEMINAR ON HIGH RISK PREGNANCY AND PROBLEMS OF THE NEWBORN, October 28-29, 1971

RADIOLOGY ONE-WEEK COURSE, November 1-5, 1971

PULMONARY DISEASE SEMINAR, November, 16, 1971

NEW MEMBERS

HENNEBERGER, GEORGE MILTON, Pascagoula. Born Washington, D. C., Nov. 22, 1930; M.D., George Washington University School of Medicine, Washington, D. C., 1958; interned Fitzsimmons Army Hospital, Denver, Colo., one year; ob-gyn residency Charity Hospital, New Orleans, La., July 1, 1956-June 30, 1962; elected July 21, 1971, by Singing River Medical Society.

JETER, MARVIN HOMER, JR., Jackson. Born West Point, Miss., Nov. 7, 1935; M.D., Tulane University School of Medicine, New Orleans, La., 1962; interned University Medical Center, Jackson, Miss., one year; medicine residency, same, July 1, 1963-June 30, 1966; elected May 5, 1971, by Central Medical Society.

LEWIS, CLYDE JAMES, Jackson. Born Meridian, Miss., Jan. 25, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1965; interned same, one year; ob-gyn residency, same, July 1, 1966-June 30, 1969; elected May 5, 1971, by Central Medical Society.

MORAN, CARL JOSEPH, JR., Raymond. Born Meridian, Miss., Nov. 27, 1942; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1968; interned St. Elizabeth Medical Center, Dayton, Ohio, one year; elected May 5, 1971, by Central Medical Society.

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tetranitrate) 80 mg

Indications: PERITRATE SA Sustained Action (pentaerythritol tetranitrate) 80 mg is indicated for the relief of angina pectoris (pain associated with coronary artery disease). It is not intended to abort the acute anginal episode but is widely regarded as useful in the prophylactic treatment of angina pectoris.
Contraindications: PERITRATE SA Sustained Action (pentaerythritol tetranitrate) 80 mg is contraindicated in patients who have a history of sensitivity to the drug.
Warning: Data supporting the use of PERITRATE (pentaerythritol tetranitrate) during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine, and many other agents.
Precautions: Should be used with caution in patients who have glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.
Adverse Reactions: Side effects reported to date have been predominantly related to rash (which requires discontinuation of medication) and headache and gastrointestinal distress, which are usually mild and transient with continuation of medication. In some cases severe persistent headaches may occur. In addition, the following adverse reactions to nitrates such as pentaerythritol tetranitrate have been reported in the literature: (a) Cutaneous vasodilatation with flushing. (b) Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. (c) An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur, ever with the usual therapeutic doses. Alcohol may enhance this effect.
Dosage: PERITRATE SA Sustained Action (pentaerythritol tetranitrate) 80 mg (b.i.d. on an empty stomach), 1 tablet immediately on arising and 1 tablet 12 hours later.
Supplied: PERITRATE SA Sustained Action (pentaerythritol tetranitrate) 80 mg, bottles of 100 and 1000 tablets.
Additional Dosage Forms: PERITRATE (pentaerythritol tetranitrate) 10 mg and 20 mg tablets with or without phenobarbital 15 mg, bottles of 100 and 1000 tablets. PERITRATE with Phenobarbital SA Sustained Action—pentaerythritol tetranitrate 80 mg and phenobarbital 45 mg, bottles of 100 and 1000 tablets.
Warning: Tablets containing phenobarbital may be habit forming. PERITRATE with Nitroglycerin—pentaerythritol tetranitrate 10 mg with nitroglycerin 0.3 mg, bottles of 50 tablets.

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PE-GP-11

Mr. Early Will Head CCS

Wayne C. Early of Jackson is the new supervisor of Crippled Children's Service, a program of the State Board of Health that served over 5,000 crippled children last year. He succeeds W. P. Bobo, who retired after directing CCS for 13 years.

In making the announcement, State Health Officer Hugh B. Cottrell said Early comes to the position after 19 years of "varied public health experiences that well equip him to administer to the ever-expanding program for Mississippi's crippled children."

A graduate of Mississippi College, Early joined the State Board of Health in 1952 and has served as a special investigator in Vicksburg, advisory coordinator of a comprehensive health survey in Harrison County and helped administer the special statewide immunization program.

In 1968, Early was appointed supervisor of the Tuberculosis Control Unit and served in that capacity until being transferred to the Crippled Children's Service.

The 35-year-old Crippled Children's Service, which was set up in the State Board of Vocational Education in 1936 and moved to the Department of Education in 1946, was transferred to the State Board of Health July 1, 1970, in compliance with legislative enactment.

For the past year, CCS has been a unit of the Division of General Health Services, with Dr. Frank M. Wiygul, Jr., the division director serving as medical director.

Dr. Tom Blake, a Jackson orthopedist, who was the medical director before the transfer, serves CCS as medical consultant.

A total of 19,032 patients were on the CCS register during the fiscal year 1970-71, and 1,773 of these were added during the year.

Clinics for crippled children were conducted on varying schedules in 14 locations in Mississippi and one location in Memphis, some in hospitals and doctors' offices, but the majority in health departments.

Holding the clinics were orthopedists, neurosurgeons, plastic surgeons, and cardiologists on contract with CCS.

Dr. Wiygul said the CCS program initially was orthopedic and plastic surgery in scope, but it now embraces many problems in the fields of neurology, cardiology, seizure control, speech and hearing.

MISSISSIPPI STATE LIBRARY

Expo I Will Feature Dr. Paul D. White

An address by Dr. Paul Dudley White of Boston, noted cardiologist and personal physician to the late President Dwight D. Eisenhower, will be a highlight of the Mississippi Health Expo I scheduled for Oct. 1-3 in the state coliseum at Jackson.

The Mississippi Heart Association is sponsoring Dr. White's lecture in the coliseum on Oct. 2. A panel of 12 heart specialists will also be available for a question and answer period.

More than 50 voluntary and state agencies are now participating and supporting the giant health fair, first of its kind to be held in the state. The state medical association is co-sponsoring the event, in conjunction with other groups.

The Expo is aimed toward the general public and there will be no admission charge. Designed for health education, health career recruitment and provision of health services, the fair includes exhibits, screening and diagnostic testing, lectures, teaching sessions, information booths, movies, and special teenage programs.

The Mississippi Hospital Association will sponsor the state convention of Candystripers simultaneously with the Expo. These volunteens will serve as ushers and guides during the three days.

Birth certificates for teenagers born 1955-56 will be provided free of charge in the coliseum by the State Board of Health.

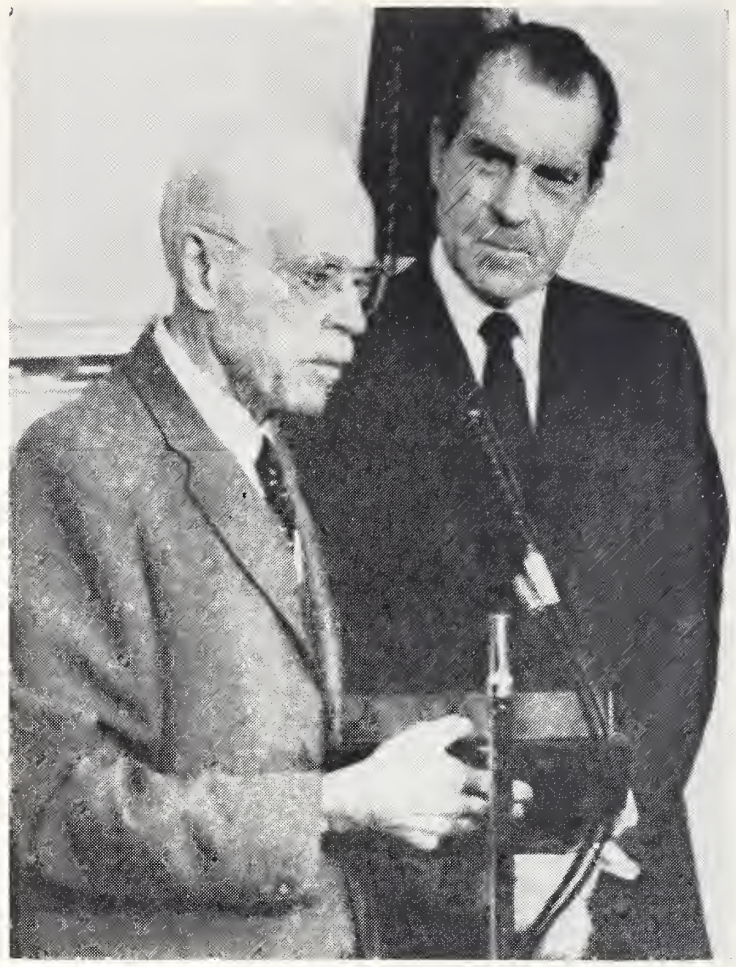
Of special interest to teenagers will be the University of Mississippi School of Pharmacy drug abuse exhibit consisting of a giant walk-in capsule with psychedelic lighting.

Screening procedures to be done at the fairgrounds include chest x-ray, glaucoma testing, SMA 12 blood tests, EKG, blood pressure and other tests. The artificial kidney machine will be demonstrated by the Mississippi Kidney Foundation.

Special films on such topics as accepting death, pollution, multiple sclerosis, glaucoma and smoking will be shown. Presentations on alcoholism, mechanical quackery, futuristic hospital situations and nutrition will also be featured.

Governor John Bell Williams is expected to offically open the Expo I at the coliseum on Oct. 1.

Dr. C. G. Sutherland of Jackson is chairman of the MSMA Expo I committee. Working with him are Drs. Raymond S. Martin, Jr., Jim G. Hendrick, and Raymond S. Grenfell, all of Jackson. A member of the association has been appointed to work on every committee of the Expo. The Woman's Auxiliary endorses the event and is sponsoring an informational exhibit on health careers to be manned by medical and nursing students.



Dr. Paul Dudley White, noted cardiologist who will appear at Mississippi Health Expo I, confers with President Richard M. Nixon.

The committee has urged physicians from throughout the state to attend the health Expo I and support the event in their respective communities.

SBH Announces Entry Requirements

Current immunization requirements at United States ports-of-entry have been announced by Dr. Durward Blakey, director of the State Board of Health's division of preventable disease control.

Arrivals who in the preceding 14 days have visited a country showing areas infected with smallpox will be required to present a valid smallpox vaccination certificate.

Those arrivals who in the preceding six days have visited an area infected with yellow fever may be required to present a valid yellow fever vaccination certificate, according to Dr. Blakey.

There are no cholera or plague requirements.

Cardiovascular Unit and Catheterization Lab Opened at Mississippi Baptist Hospital

With the opening of the state's first cardiovascular unit in a voluntary hospital, physicians are now doing open-heart surgery at Mississippi Baptist Hospital in Jackson.

Establishment of the new unit was announced by Zach T. Hederman, president of the hospital's board of governors, and by Paul J. Pryor, hospital administrator.

Dr. H. Davis Dear of Jackson has been appointed director of the cardiovascular unit and will serve as full-time cardiologist on the hospital staff, said Hederman.

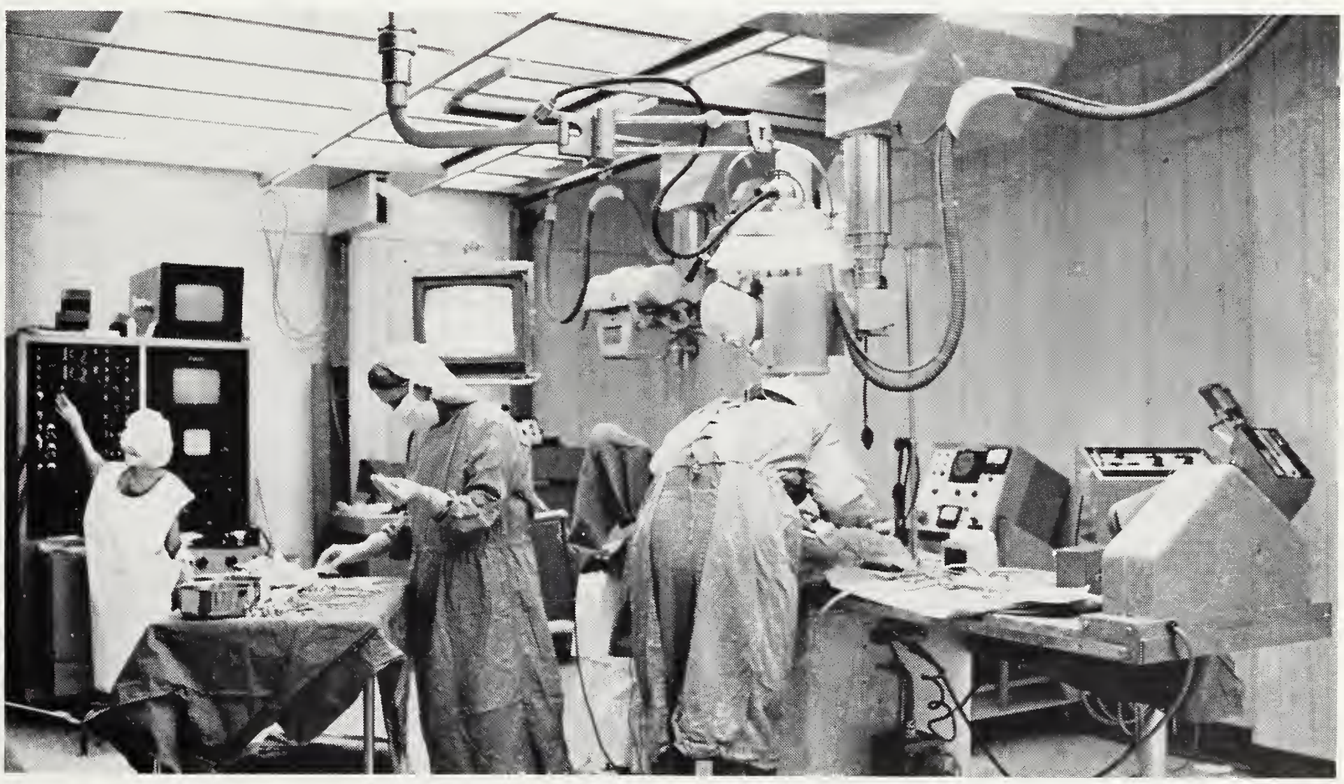
The unit includes a laboratory with equipment for cardiac catheterization, facilities for exercise testing of the heart, operating suites, a recovery section of 23 beds, and a coronary intensive care unit with continuous electronic monitoring of each heart patient.

"There are few heart defects now," said Dr. Dear, "which cannot be repaired, and units like this one are going to enable many people to live a lot longer." He estimates that as many as four or five open heart surgery operations a week will be performed in the unit in the near future.

"The addition of this unit," said Pryor, "means that the entire hospital offers special services to those with heart defects, not only in this unit but in its coronary care unit as well."

The University of Mississippi Medical Center has a heart catheterization laboratory, the only other one in the state.

Dr. Dear pointed out that with the addition of the second such unit in the state, fewer heart pa-



A heart catheterization procedure gets underway in the hospital's new cardiovascular laboratory.

tients will have to be sent out of state for needed treatment.

With the unit's facilities for open heart surgery including the heart-lung pump, heart valves can



Dr. Albert L. Meena of Jackson, chief of the medical staff at Mississippi Baptist Hospital, and Administrator Paul J. Pryor, right, examine equipment newly installed in the unit.

now be replaced, grafts can be made and lesions can be sewn up or repaired at Baptist, said Dr. Dear.

The unit has specially trained personnel to work with the medical team, said Pryor. He pointed out that hospital personnel were sent to medical education centers across the country for this training.

Dr. Dear is a native Jacksonian and received his M.D. degree from the University of Mississippi School of Medicine. He interned at Yale Medical School and did his residency at Yale-New Haven Hospital, then served a cardiology fellowship at the University of Alabama Medical Center in Birmingham.

Dr. Jones Authors External Ear Chapter

Dr. Edley H. Jones of Vicksburg was chosen to write the new chapter on Diseases of the External Ear in the annual publication of loose-leaf Otolaryngology.

The publication was begun some 20 years ago by W. F. Prior Company. Each set consisted of five volumes and an index and each volume contained many separate chapters on various phases of otolaryngology.

The management has now changed to Harper and Row but the service has continued and each year the subscribers receive new chapters on various subjects, discarding the old chapter.

Dr. Jones practices in the Eye, Ear, Nose and Throat Clinic at 1301 Washington Street in Vicksburg. He is a member of AMA, MSMA, West Mississippi Medical Society, and is a Fellow of the American College of Surgeons.

CHAMPUS Establishes Local Offices

U. S. Army posts, camps and stations have established official CHAMPUS advisor offices to provide information and assistance to beneficiaries of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

A new Department of the Army Circular 40-78 dated June 10, 1971, has responded to the information needs of the rapidly growing hospital and health benefits program by assigning local responsibility for providing CHAMPUS information and assistance to the medical facility of each Army installation.

When no medical facility exists on an installation, the circular states, another responsible office will be designated to provide beneficiaries with information and assistance. These offices will receive assistance from the nearest medical facility and the Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) Denver, CO 80240.

The location and telephone number of the CHAMPUS Advisor's office will be given maximum local publicity, according to DA Circular 40-78. Each CHAMPUS Advisor will maintain informational material, coordinate a local information program as well as provide counselling to beneficiaries and their sponsors.

CHAMPUS officials in Denver note that establishment of the local CHAMPUS Advisor office will assist in decreasing an apparent lack of information and eliminate much of the misinformation concerning the CHAMPUS.

CHAMPUS Advisors are not limited to U. S. Army installations. The U. S. Air Force has designated CHAMPUS Advisors for their installations, while the U. S. Navy has appointed Health Benefits Counselors to assist beneficiaries of the program at each of their stations. The U. S. Coast Guard has assigned this advisory responsibility to the medical branch within each of their district offices.



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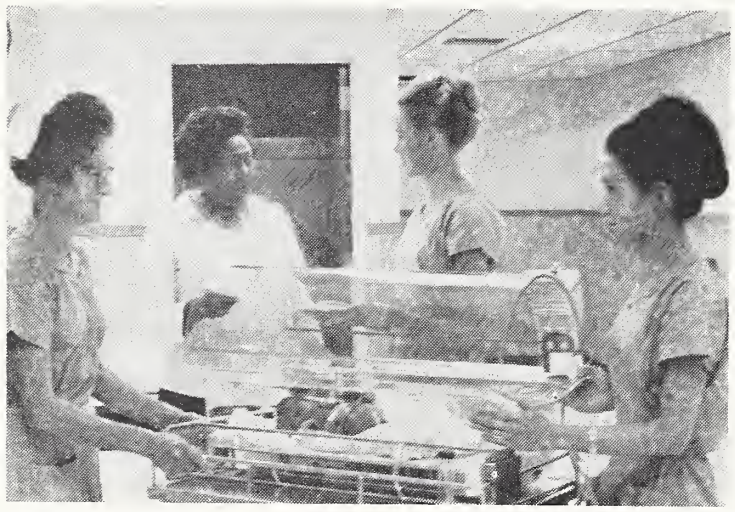
UMC Opens Ob-gyn Unit and Nursery

A new obstetric and gynecology unit and a newborn nursery in the round opened at University Hospital in late June.

Construction funds for the $1,100,000 addition came from the 1966 state legislature and matching dollars awarded through the Commission on Hospital Care.

The ob-gyn beds are on the fourth floor of the rectangular neck joining the east-west wings of the University to the children's hospital. All rooms are private and each has shower/sitz bath accommodations and telephone.

The new nursery, on the fourth floor of the children's hospital, is for both private patients and patients who pay less than full charges. Forty-eight of its 82 bassinets are for full-term, normal infants; 15 are in a central intensive care unit; five are designated for extremely high risk infants; 10 for convalescing premature babies; and four for infants who must be isolated from other babies.



From left, L.P.N. Mrs. Lavada Kight, assistant ward manager, Mrs. W. C. Conic, delivery suite head nurse Miss Jerri Thompson and R.N. Mrs. Suh Chang welcome the first patient to the nursery.

Medical center officials say activation of the new nursery will allow the University to admit more babies born elsewhere with problems that can't be handled at the community level.

M.D. Program for Ph.D.'s Launched

Twenty Ph.D. scientists will obtain a medical degree in two years in an experimental program of medical education to be conducted by the University of Miami School of Medicine under government contract.

The accelerated training course for holders of doctoral degrees in biological, physical, and engineering sciences will be supported by a $163,-859 contract from the Division of Physician and Health Professions Education, Bureau of Health Manpower Education (BHME). BHME is a component of the National Institutes of Health.

"This is one of several new approaches by this Bureau toward relieving the physician shortage as quickly as possible," said Dr. Kenneth M. Endicott, BHME Director.

Under the retraining plan, those accepted into the special M.D. program will pursue a curriculum in the basic sciences tailored to their individual needs, which, in five months, will bring them up to the proficiency of the regular M.D. student at the end of the sophomore year. This curriculum will consist of specially designed courses in biochemistry, biological structure, and physiology followed by a 12-week core course in microbiology, pathology, and pharmacology that forms a part of the normal sophomore program. The 48-week core clinical training which follows will be identical to the present third year M.D. curriculum. Seven months will be allowed for elective study or added work in basic sciences.

Students will be taught in groups of three and each group will have two faculty counselors; one, a basic scientist, and the other, a clinician, who will act as advisors until the degree is awarded.

Dr. Harry W. Bruce, Jr., division director, who announced the award, pointed out that if the University of Miami experiment is successful and is adopted by other medical schools in the country, it could result in a substantial increase of the number of physicians within a radically shortened time span.

"By taking advantage of the fact that most of these Ph.D. scientists have already satisfied many of the medical school requirements for two years of basic science, this innovation could also cut the cost of their medical education," Dr. Bruce said. "And it could also reclaim for the use of society, knowledge and skill now going to waste."

William J. Whelan, D.Sc., chairman of the department of biochemistry, University of Miami School of Medicine, will direct the retraining project.

Auxiliary Leaders Attend Convention



Three Woman's Auxiliary presidents participated in the Woman's Auxiliary to the American Medical Association annual convention in Atlantic City. From left are Mrs. T. E. Ross, III, of Hattiesburg; 1971-72 president; Mrs. Paul B. Brumby of Lexington, past president and wife of the immediate past president of MSMA and a Board member; and Mrs. Curtis W. Caine of Jackson, immediate past president of the auxiliary.

U.S.P. Convention Announces New Members

Fifteen delegates representing medicine and pharmacy have presented their credentials and been approved as members of the U.S.P. Convention, announces Dr. William M. Heller, executive director.

The U.S.P. Convention is the only national bi-professional organization equally representing the interests of both pharmacy and medicine. The Convention membership is comprised of members from each school of medicine and pharmacy, each state medical and pharmaceutical association, health branches of the federal government and specified national organizations of medicine and pharmacy.

Each eligible organization is allowed one delegate. As a member of the U.S.P. Convention, he serves as the channel by which his organization is apprised of, and comments on, the U.S.P. functions of designating the best, established drugs and establishing public standards for them, as well as giving consideration to new concepts being developed for the U.S.P.

The new Convention members and the organizations they represent are as follows: Dr. Stanley L. Burns, Vermont State Medical Society; Dr. Murray Heimberg, Vanderbilt University School of Medicine; Dr. David C. Johnson, Nevada State Medical Association; Dr. R. W. Kellermeyer, Case Western Reserve University School of Medicine; J. Maxwell Little, Ph.D., Bowman Gray School of Medicine of Wake Forest University; and Dr. James E. O'Brien, Connecticut State Medical Society.

Other new members are: C. Alvin Paulsen, Washington State Medical Association; Dr. Bernard E. Tilton, Loma Linda University School of Medicine; Dr. Stephen A. Tzianabus, New Hampshire Medical Society; Dr. Roy S. Weinrach, Arizona Medical Association; R. David Anderson, American Society of Hospital Pharmacists; Thomas P. Faulkner, Ph.D., Texas Southern University School of Pharmacy; Arnold J. Hennig, Ph.D., University of Colorado School of Pharmacy; S. Charles Savio, Pharmaceutical Society of the State of New York; and Dr. Leo E. Hollister, American Society of Clinical Pharmacology and Therapeutics.

Hire the Handicapped Program Set

Kicking off the national Hire the Handicapped Week, the Governor's Committee on Employment of the Handicapped will hold a half-day program to bring together various related state agencies and Mississippi employers who hire the handicapped.

Set for Monday, Sept. 27 at Primos Northgate Restaurant in Jackson, the affair will begin with a dinner. Charles B. Ryan of Jackson, president of MPI Industries Division of DeSoto, Inc. and chairman of the Governor's committee, will preside over the program.

Featured speakers include Harold Russell, nationally known handless individual who heads two private companies and is chairman of the President's Committee for Employment of the Handicapped, and Dr. Frank Cotton, head of the Department of Industrial Engineering at Mississippi State University.

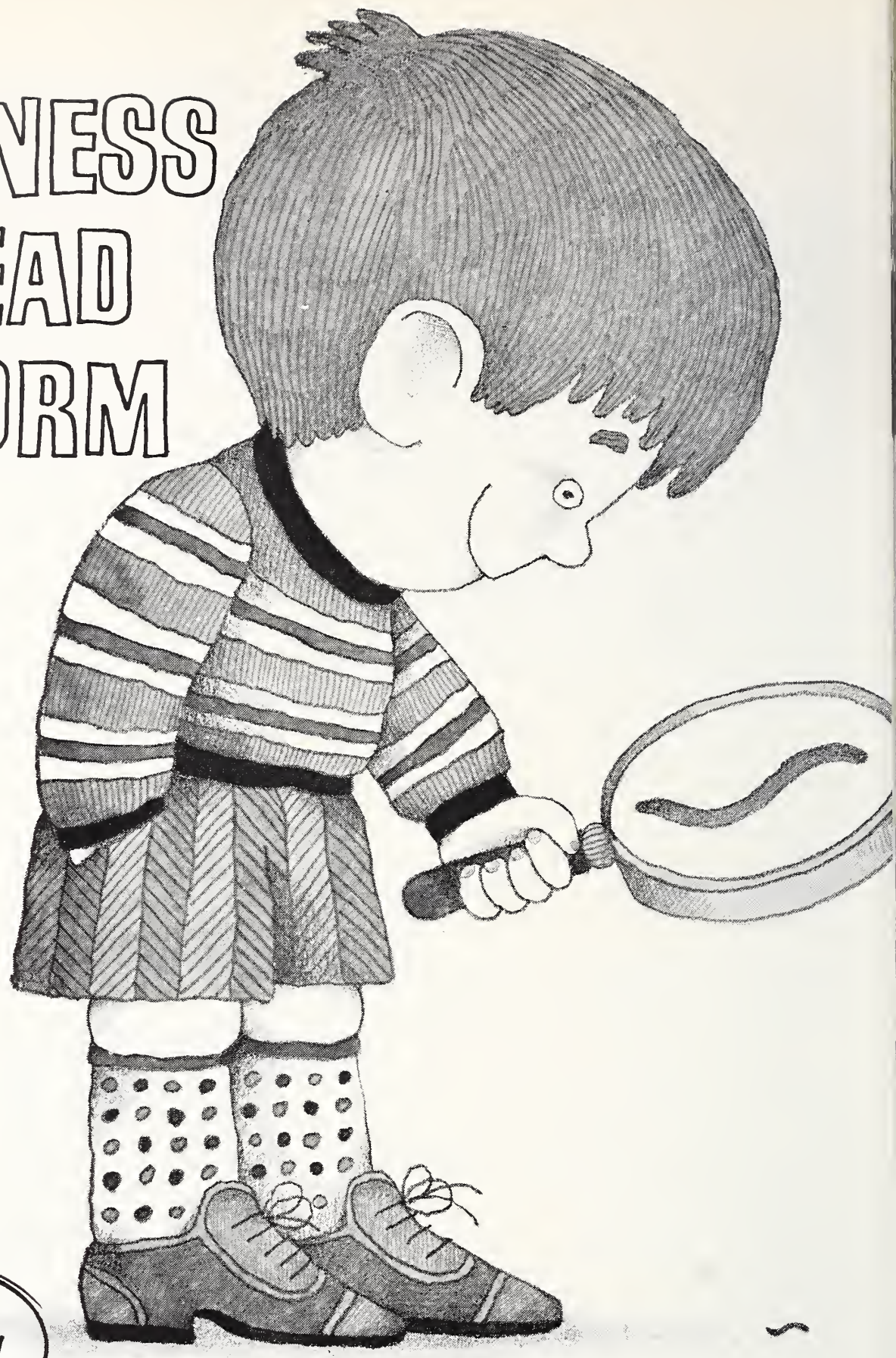
Governor John Bell Williams will receive the Distinguished Service Award from Mr. Russell of the President's Committee and he will comment on the importance of hiring the handicapped.

Preregistration is requested and there will be a $5.00 fee per person.

For further information write: Mississippi Governor's Committee on Employment of the Handicapped, P.O. Box 1698, Jackson 39205.

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Contraindications: History of hypersensitivity to thiabendazole.

Warnings: May impair alertness; operation of automobiles and other activities made hazardous by diminished alertness should be avoided. If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed; erythema multiforme, including Stevens-Johnson syndrome (with a fatal case), has been associated with thiabendazole therapy in children. Safe use in pregnancy or lactation has not been established.

Precautions: Since thiabendazole is metabolized in the liver and excreted by the kidneys, hepatic and renal function should be carefully monitored in patients with dysfunction of these organs.

Adverse Reactions: Frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, collapse, abnormal sensation in eyes, blurring of vision, hyperirritability, numbness, hyperglycemia, xanthopsia, enuresis, perianal rash, cholestasis and parenchymal liver damage, hypotension, and a transitory rise in cephalin flocculation and SGOT. Hypersensitivity reactions include: fever, facial flush, chills, conjunctival injection, angioedema, anaphylaxis, skin rashes, erythema multiforme (including Stevens-Johnson syndrome), and lymphadenopathy. Appearance of live Ascaris in the mouth and nose has been reported on rare occasions.

Some patients may excrete a metabolite which imparts an odor to urine, much like that which occurs after ingestion of asparagus. Crystalluria without hematuria has been reported on occasion, but has promptly subsided with discontinuation of therapy; while the etiologic role of thiabendazole has not been established, the possibility of crystalluria should be kept in mind. Transient leukopenia has been reported in a few patients, but the cause and effect relationship in these cases has not been established.

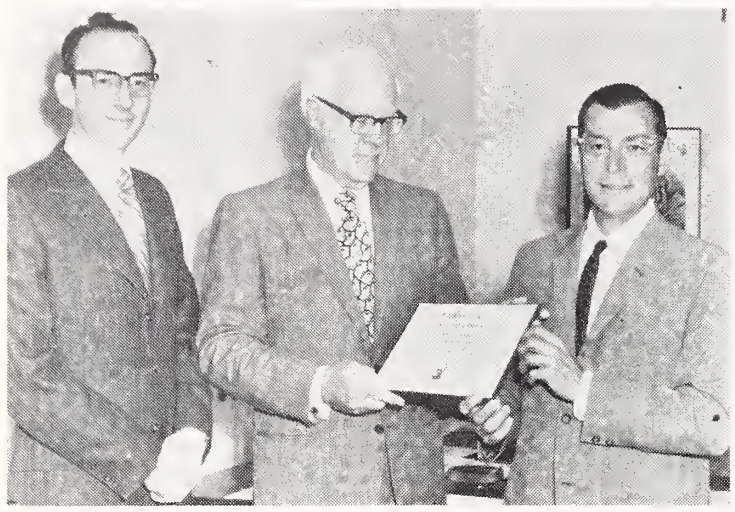
NOTE: In children weighing less than 30 pounds, clinical experience with thiabendazole for treatment of intestinal parasitosis has been limited. Thus, the benefits of this therapy should be weighed against the possibility of adverse reactions.

Supplied: Suspension, containing 500 mg per 5 cc, in bottles of 120 cc.

For more detailed information, consult your MSD representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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ACOG Presents Certificate to Searle



The American College of Obstetricians & Gynecologists has presented a certificate of appreciation to G. D. Searle & Co., pharmaceutical manufacturer based in Skokie, Ill. Searle has had a medical exhibit at every annual meeting of ACOG, and helped support publication of the college's recently published history.

The American College of Obstetricians & Gynecologists, founded in Chicago 20 years ago, was represented at the presentation by Donald F. Richardson (center), executive director. Accepting the certificate for Searle were William L. Searle (right), senior vice president, Domestic Pharmaceutical Division, and Donald A. Paul, medical meetings manager.

UAB Releases Enrollment Figures

Summer 1971 enrollment at the University of Alabama in Birmingham (UAB) has increased more than 31 per cent over last summer, with every unit of UAB experiencing a substantial rise in number, according to statistics recently released.

A total of 6,021 students are enrolled now, compared with last summer's enrollment of 4,610. During the 1971-72 school year, more than 8,000 persons are expected to enroll at UAB.

In the Medical Center and the College of General Studies, advanced professional and graduate enrollees number 1,236, which is 21 per cent of the total UAB student body and 32 per cent more than last fall's enrollment in programs beyond the bachelor's degree level.

The College of General Studies experienced a 31 per cent increase over last summer. The 5,031 enrollees include students taking work in credit, non-credit, undergraduate, graduate, nursing, and allied health programs.

The UAB Graduate School, with its programs in both the College of General Studies and the Medical Center, experienced a 23 per cent enrollment rise.

There is a total of 3,641 men and 2,380 women enrolled at UAB.

Pall Expands Blood Filter Line

The Biomedical Products Division of Pall Corporation, Glen Cove, New York, announces the expansion of its disposable blood filter line. The development of two new units now makes the filter available with either ⅜″ tubing connections, ¼″ tubing connections or luer fittings. The expanded line offers the versatility needed to filter out microemboli generated during cardiopulmonary bypass procedures in open heart surgery and the removal of minute particles from transfused blood.

Pall's Disposable Blood Filter with ⅜″ tubing connections, already in wide use, has proven to be highly effective in removing microemboli in open heart procedures. The filter assembly with ¼″ tubing connections is convenient for ¼″ lines commonly used for coronary perfusion and suction. The assembly with luer fittings can be readily connected to conventional transfusion sets to provide the same removal capability in transfused blood. All filters are provided with capped female luer vents for easy priming.

The Pall Disposable Blood Filter assembly consists of an accordian folded polyester element in a polypropylene housing. Its pore size of 40 microns allows blood cells to pass through freely and removes only the damaging microemboli. These characteristics permit high flow rates with no increase in hemolysis. The filter is autoclavable and has a priming volume of 190 cc.

For further information about Pall Disposable Blood Filters, contact the Biomedical Products Division, Pall Corporation, 30 Sea Cliff Avenue, Glen Cove, New York 11542. Tel: 516-671-4000.

IRS Clarifies Withholding Procedures

Some people are not having enough federal income tax withheld from their paychecks, and may wind up owing the government a large amount when they file their 1971 return, J. G. Martin, Jr., district director of Internal Revenue Service for Mississippi, has announced.

Those people in this category should arrange for additional withholding with their employer, who has been furnished information necessary for that purpose.

This information could be useful to physicians in adjusting the tax for their employees.

The standard deduction, formerly 10 per cent, has been increased to 13 per cent. The withholding system allows a 13 per cent deduction for all wage earners who are not entitled to the low income allowance.

However, the standard deduction is limited to $1,500 on the tax return. For example, the withholding tables assume that a single tax payer with a $15,000 income will have 13 per cent, or $1,950, in deductions. But when the taxpayer fills out his return and takes the $1,500 standard deduction, or $450 less than the deductions allowed for withholding, he will generally wind up owing tax. The same taxpayer would have a similar problem if his itemized deductions were less than 13 per cent of his income.

Another withholding problem arises when both husband and wife are employed. Although the withholding system gives each employee the new low-income allowance, the couple is entitled to only one low-income allowance when filing a joint return.

In addition, employees with high incomes may have too little withheld because the maximum withholding rates are limited to 24 per cent for single persons and 25 per cent for married persons.

Taxpayers most likely to need more withholding are: employees who expect to earn more than $11,500 in 1971 and intend to claim the $1,500 standard deduction or itemized deductions totaling less than 13 per cent of their salaries; single employees who expect to earn $15,000 or more in 1971; married employees who expect to earn $25,000 or more in 1971 and whose spouses are not employed; and all working couples.

Employees who are not reasonably sure that enough tax is being withheld should estimate the amount to be withheld during 1971 from the tables IRS has made available to their employers, the IRS said. They should then compare this estimate with the amount of tax liability on their expected income for 1971. If more withholding is necessary, the taxpayer should file a new exemption certificate (Form W-4) with his employer and claim fewer exemptions, or ask to have specific additional dollar amounts withheld.

Martin cautioned against confusing the tax tables and rate schedules for *1970,* already mailed to taxpayers, with the *1971* tables and rates made available to employers.

Medical Assistants Revise Curriculum

A second step has been taken toward assuring quality education for medical assistants. Standards have now been revised to allow greater curriculum flexibility. Principal changes include the development of a basic one-year curriculum and allowance for medical specialty courses within the existing two-year program.

In addition, the curriculum may be established in vocational-technical schools, proprietary educational institutions, and military-based schools as well as junior, community and senior colleges. Adequate clinical facilities are one of the requirements for approval.

The revised standards or "essentials" supplement the original two-year medical assisting curriculum developed jointly by the American Medical Association (AMA) and the American Association of Medical Assistants (AAMA) two years ago.

Mrs. Marian G. Cooper, CMA, chairman of AAMA's Curriculum Review Committee, pointed out that "with these changes, AAMA can make available a single package of standards. The one-year curriculum," she said, "offers the fundamentals of medical assisting for students who must limit their advanced education. It provides a basic knowledge of anatomy and physiology, medical terminology, medical law and ethics, psychology, bookkeeping, insurance claims, and clinical procedures. This program leads to a one-year medical assisting certificate.

"The two-year program," Mrs. Cooper continued, "leads to an Associate degree and offers both basic and advanced medical assisting courses, including the humanities and social sciences or electives in a particular medical specialty.

"Although advanced education for medical assistants is relatively new, more and more physicians are requiring it. Years ago a doctor could

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Please see facing column for summary of contraindications, precautions, and adverse reactions.

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Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.

Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.

Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.

Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.

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train his medical assistant on the job. However, the increasing demands for health care have made it necessary for him to look for employees already qualified," she concluded.

Most medical assistants are employed in a physician's office or other medical facility under such job titles as medical assistant, medical secretary, receptionist, bookkeeper or medical office manager. They are the direct link between the physician and his patients, his professional associates, and the suppliers of equipment and medications.

For further information contact the American Association of Medical Assistants, One East Wacker Drive, Chicago, Ill. 60601.

Chest Physicians Plan Meeting

The Southern Chapter of the American College of Chest Physicians, in cooperation with the Southern Medical Association, will hold its 28th Annual Meeting, Nov. 1, 1971, at the Fontainebleau Hotel in Miami Beach.

The one-day Annual Meeting will be divided into three parts. Presentation of scientific papers, 18th Annual Paul A. Turner Memorial Lecture, and Symposium on Pulmonary Embolism. Dr. Donald A. Paulson, Dallas, will deliver the Paul A. Turner Memorial Lecture on "Selectivity for Surgery in Bronchogenic Carcinoma: An Overview of Current Thinking."

Other aspects of the meeting will consist of lectures by prominent physicians in the areas of chest disease, lung cancer, and the role of the cardiologist, pulmonary physiologist, radiologist and surgeon in pulmonary embolism. There will be two intermissions to visit exhibits and a question and answer period at the end of the day, followed by a reception at the Louis Philippe Room.

Registration begins at 8:30 a.m. and no registration fee is required. For further information, write the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611 or call (312) 787-4933.

Guide to Prescription Prices Published

A new medical reference book that provides physicians with prices their patients may expect to pay for the most commonly prescribed brand name as well as generic drugs was announced recently.

Based on computer-processed statistical data gathered by the publisher (WILCOM Educational Development Company, Fayetteville, N. Y.), the new medical reference book, *Physicians' Guide to Prescription Prices,* provides a new tool for the physician.

A recent survey by the publisher showed, with few exceptions, that physicians clearly needed a reliable source of prescription price information. Until now, the doctor was required to make a decision to buy without any source of knowledge about the price of the product he was responsible (through his prescription) for purchasing.

According to William D. Gulick, president of WILCOM, the physician for the first time now has access to reliable information concerning the different prices of various drugs. Not only can he now make prescribing decisions on the basis of safety and effectiveness, but also by comparing the prices of numerous other equally suitable therapeutic agents.

Physicians' Guide to Prescription Prices provides price information on all the most commonly prescribed brand name and generic products. Listed is the average price the patient may expect to pay per dosage unit for a commonly prescribed quantity of any particular drug.

In addition to prices, the *Guide* provides corollary medical prescribing information. This data is grouped in a unique "Medical Almanac" section that includes metric and apothecary weights and measures; conversion tables; growth and development charts; Poison Control Centers, with their emergency telephone numbers, and an extensive collection of other essential medical prescribing data—all compiled in one book for the physician's convenience.

Gulick reported that his company's studies indicated that, as the general cost of living continues to rise, physicians are becoming more concerned about the cost of drugs they prescribe.



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New Baptist Hospital Financing Is Approved

The Mississippi Baptist Convention Board has given unanimous approval to the board of trustees of Mississippi Baptist Hospital to finalize the financing for the largest single project ever carried out by the hospital.

The program calls for the construction, beginning in summer of 1972, of a completely new $25,000,000 hospital (six floors plus basement) accommodating 600 beds, according to Zach T. Hederman, president of the hospital board.

The convention board authorized the hospital board to borrow up to $22,000,000 for the program. Almost $2,000,000 in gifts and pledges was raised during the statewide campaign last year and contributions continue to come in.

In preparation for the expansion, conferences between the hospital representatives and architects have been under way for over a year, and architectural design is now being refined preparatory to the breaking of ground approximately one year from now.

The new hospital, with half a million square feet of floor space, will be located on the northwestern corner of the intersection of North State and Manship streets, diagonally across the street from the present hospital which will continue to be used.

Mississippi Baptist Hospital is already the state's largest voluntary hospital with 400 beds. Some four years from now, it will become a major medical complex of 1,000 beds, said Hederman.

An area just north of the new hospital will accommodate approximately 100 automobiles for the hospital medical staff, and plans are being made for public parking within easy walking distance of the hospital.

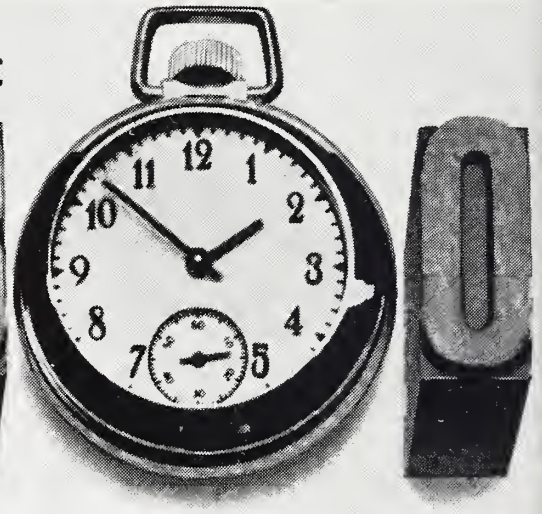
The top four floors will consist of four Y-shaped wings with 36 beds on each wing, or 144 beds per floor. The second floor will include the surgical suite, radiography complex, radioisotope rooms, clinical laboratories and a cardiovascular unit.

In the basement will be dietary, engineering, materials management, central processing, central supply, medical records, housekeeping, pharmacy, education, mail room and other units, with access to employees at ground level.

The first floor will include the emergency rooms, outpatient clinic, therapy areas, administrative offices, admitting area, lobby, personnel office, purchasing office, a cafeteria for 400, a chapel, and gift shop.

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Before prescribing, please consult complete product information, a summary of which follows:
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WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.
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Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.
PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.
ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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IN CONCLUSION

Fastest growing form of health insurance covers dental services, according to the Health Insurance Institute. More than 10 million Americans now have "scheduled" or "comprehensive" coverage. Former is indemnity, while comprehensive involves family deductible with co-pay on covered ranges. American Dental Association says that half of Americans have inadequate dental care, that four out of five have gum disease, and that one child in four has bad occlusion.

Good times first and good health second seems to be America's motto, if Bureau of Labor Statistics data are indication. Last year, we spent $16.4 billion on booze and $14 billion for physicians' service Bill for recreation was $36.3 billion against $18 billion for hospit care. Barbers and beauticians got $9.7 billion, but only $6.2 billi went for prescription drugs. Despite warnings, Americans increased use of tobacco, spending nearly $11 billion for smokes.

Dr. Richard S. Wilbur, newly named Assistant Secretary of Defense for Health, has proposed substantial pay increases for military medical officers to permit volunteer services. He also says that drug addiction in armed forces is extremely serious problem which will command his immediate attention. The new assistant secretary, appointed in June by President Nixon, is on leave from post of Deputy Executive Vice President of AMA.

Federal expenditures for hospital services have increased 250 per cent under Medicare and Medicaid. HEW says that in 1965, federal government paid 13 per cent of nation's hospital bill. Five years later, it is paying nearly 32 per cent of tab. During same period, states' share of hospital payments has decreased to 17 per cent from 23 per cent in 1965. Figures are really deceptive and outlay is much greater than percentages show because of hospital costs rise.

California Medical Association, traditionally an innovator in health care delivery, will introduce a national health insurance program of its own in Congress. CMA program would be voluntary but otherwise i close to AMA Medicredit plan, allowing income tax credit for purchas of coverage. Federal share would be paid from general revenues with no special tax for health care services. Program would also abolish Medicare and Medicaid.

Volume XII
Number 10
October 1971

JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $7.50 per annum; $1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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Because bacterial proliferation in the urine is a function of time and retention,[1,2,3] *dawn can be...*

the darkest hour.



NEWSLETTER

October 1971

ear Doctor:

inal corporate organization of Mississippi Foundation for Medical are has been completed as MSMA-sponsored, wholly owned subsidiary. pplication forms for participating membership will be included in ct. 15 billing statements for 1972 dues to all members. No dues re charged for Foundation membership in 1971-72. Initial program s education on goals and purposes of Foundation.

> Billing for dues will again offer advantage of combined payment and legal record for income tax deduction. AMA dues for 1972 are voluntary, but all are encouraged to pay. Also included will be local and state dues, MPAC and AMPAC dues, Auxiliary dues for wife, and AMA-ERF.

ction by House Ways and Means Committee on national health insurance in present session of the Congress is now virtually ruled out. hairman Wilbur Mills (D.,Ark.) says that time available must be sed to consider the aftermath of President Nixon's economic freeze. ut chances are that House-passed Social Security Amendments will be cted on by Senate with deletion of controversial welfare reform.

Labama legislature seems intent on wiping out medically-oriented tate Board of Health by reducing physician membership to minority. ouse has already passed version which would include veterinarians, entists, nurses, pharmacists, optometrists, public, and labor members. Similar measure was sponsored in Mississippi Legislature this ear but failed. Many observers look for replay in 1972 session.

wo state medical associations, California and Oklahoma, are having econd thoughts on abolishing unified membership to include AMA. In klahoma, delegates voted to keep required AMA membership, and survey n California shows 78 per cent of local society leadership favoring nified requirement. In most state medical associations, AMA membership is voluntary with only local and state required.

DA has once again turned thumbs down on Laetrile, the cancer nostrum, hich has been promoted for nearly 30 years. Newest report says that o acceptable evidence of therapeutic effect to justify clinical trials xists. Quack drug is made from apricot seeds and is stock in trade or across-the-border Mexican "cancer clinics" which attract thousands f gullible Americans annually, usually to their detriment.

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Rowland B. Kennedy
Executive Secretary



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Texas Plans Tumor Seminar

"Endocrine and Non-endocrine Hormone Producing Tumors" will be the topic of the 16th Annual Clinical Conference scheduled for Nov. 11-12, 1971, at the Shamrock-Hilton Hotel in Houston.

The meeting is sponsored by The University of Texas M. D. Anderson Hospital and Tumor Institute at Houston and the University's Division of Continuing Education of the Graduate School of Biomedical Sciences.

Seven major sessions will deal with clinical, diagnostic and research aspects of non-endocrine hormone producing tumors, pituitary tumors, pancreatic tumors, primary aldosteronism and other adrenal tumors, parathyroid tumors and the thyroid tumors, hydatidiform and choriocarcinoma.

Participating on the program will be Drs. O. H. Pearson, Case Western Reserve University School of Medicine; John H. Lawrence, University of California at Berkeley; Fred Barter, National Institutes of Health; W. D. L. Myers, Sloan-Kettering Institute; Harold Brown, Baylor College of Medicine; Jerome W. Conn, University of Michigan Medical Center; Edgar S. Gordon, University of Wisconsin; and John T. Potts, Massachusetts General Hospital.

Anderson participants include Drs. Sidney Wallace, Milam E. Leavens, Richard H. Jesse, Bruce MacKay, Naguib A. Samaan, Raymond Alexanian, Richard G. Martin, Michael L. Ibanez, Robert C. Hickey, R. Lee Clark, C. Stratton Hill, William O. Russell and Julian Smith.

Drs. Samaan and Hill will serve as chairman and co-chairman respectively.

The meeting will be highlighted by the presentation and lecture for the Heath Memorial Award, which is presented annually to a physician or scientist who has made outstanding contributions to improved care for the cancer patient through clinical application of basic research knowledge. The award was established in 1965 by William W. Heath, former chairman of The University of Texas System Board of Regents, and his wife in the memory of Mr. Heath's brothers.

On Nov. 13 a symposium on endocrine tumors will be sponsored by M. D. Anderson's department of anatomical pathology and the Texas Society of Pathologists. The meeting will be at 9 a.m., Anderson auditorium, Texas Medical Center. The panel discussion by Anderson staff members will review the diagnosis and management of patients with tumors of the endocrine tissues.

DATELINE

Optometrists Sue Harris County MDs

Houston - The Harris County (Texas) Optometric Society has filed a $3 million antitrust suit against the Harris County Ophthalmological Society, alleging that the MDs have boycotted an interdisciplinary dyslexia program. Optometrists charge withdrawal of ophthalmologists will cost plaintiffs $3 million in fees over three year program. Declaration also cites resolution adopted by ophthalmologists declining to work with optometrists. MDs are filing motion to dismiss.

CHAMPUS Restricts United Medical Lab

Denver - The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) ruled that no further payment may be made for cytology services performed by United Medical Laboratories of Portland, Ore. HEW made determination on basis of personnel qualification and decertified UML for procedures. Payment will be made for services by Mississippi pathologists and laboratories, as always, at usual, customary, and reasonable fees.

Alabama Solons Tighten X-ray Use

Montgomery - Alabama legislature has passed bill requiring that those who operate x-ray machines with output of 200 milliamperes or more be either physicians or licensed radiologic technicians. Move is seen as measure to take x-ray out of hands of chiropractors who are licensed in sister state. Paradoxically, legislature has also passed bill to permit chiropractors to file claims for services under voluntary health insurance programs.

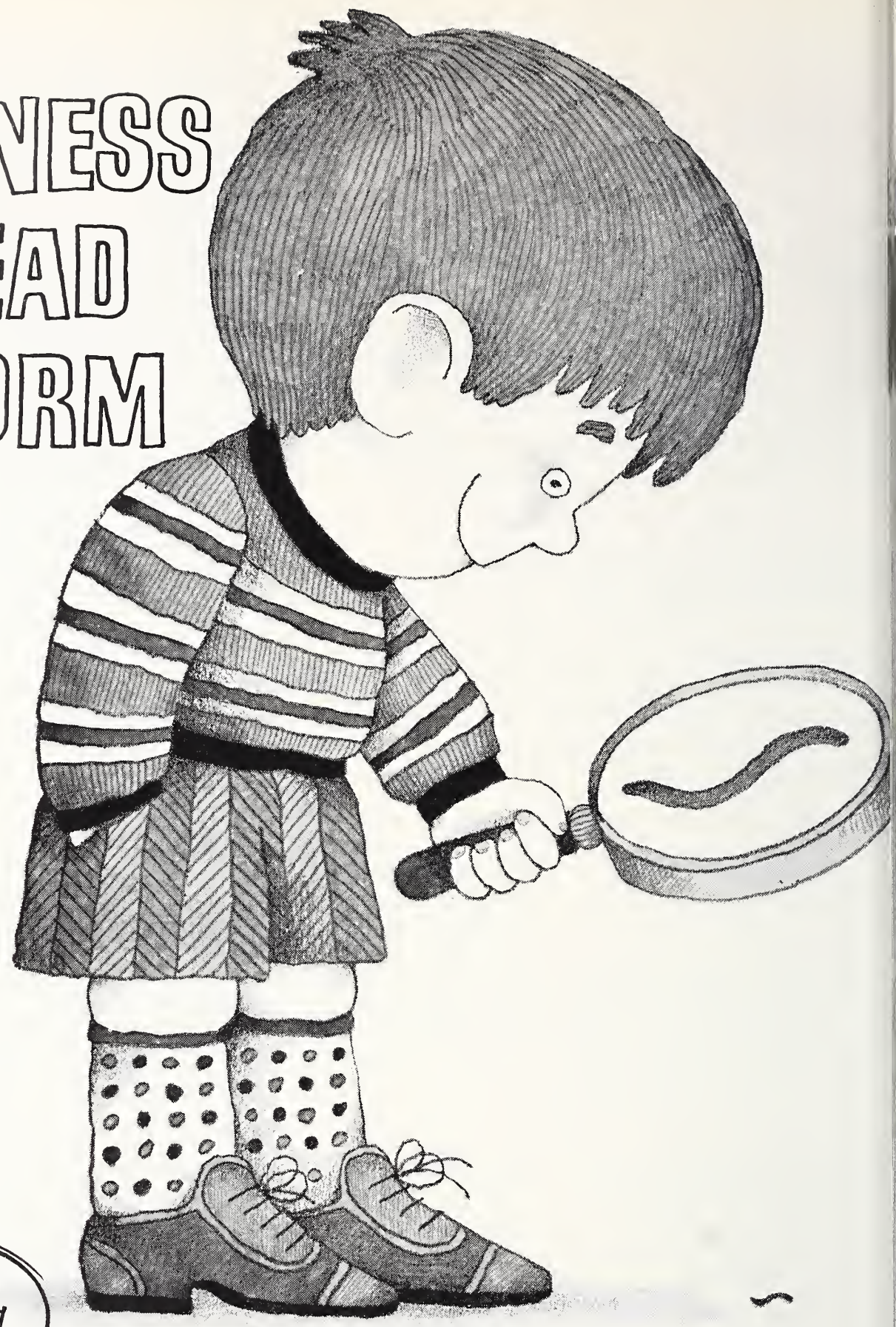
State Medicaid Adopts Formulary

Jackson - The Mississippi Medicaid Commission, fighting mounting costs of prescription drugs under state program, has adopted a formulary for use by physicians and pharmacists. After first full fiscal year, drugs lead costs with almost 24 per cent of expenditures. Nursing home and hospital costs follow with physicians receiving 17 per cent, least of all. Some pharmaceutical manufacturers have protested new formulary where products were cut from authorized list.

AMA-ERF Hits $50 Million Mark

Chicago - The American Medical Association Education and Research Foundation reached another milestone by having guaranteed $50 million in loans to medical students, interns, and residents. Almost 45,000 loans have been made with six out of 10 by medical students. Residents account for a third and rest is by interns. AMA-ERF underwrites guarantees of loans by 12 major banks in U.S., one of which is Deposit Guaranty National Bank of Jackson.

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MINTEZOL isn't a dye. So you won't hear complaints about stained teeth, clothing, or bed linen. The most frequently occurring side effects have been anorexia, nausea, vomiting, and dizziness.



Contraindications: History of hypersensitivity to thiabendazole.

Warnings: May impair alertness; operation of automobiles and other activities made hazardous by diminished alertness should be avoided. If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed; erythema multiforme, including Stevens-Johnson syndrome (with a fatal case), has been associated with thiabendazole therapy in children. Safe use in pregnancy or lactation has not been established.

Precautions: Since thiabendazole is metabolized in the liver and excreted by the kidneys, hepatic and renal function should be carefully monitored in patients with dysfunction of these organs.

Adverse Reactions: Frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, collapse, abnormal sensation in eyes, blurring of vision, hyperirritability, numbness, hyperglycemia, xanthopsia, enuresis, perianal rash, cholestasis and parenchymal liver damage, hypotension, and a transitory rise in cephalin flocculation and SGOT. Hypersensitivity reactions include: fever, facial flush, chills, conjunctival injection, angioedema, anaphylaxis, skin rashes, erythema multiforme (including Stevens-Johnson syndrome), and lymphadenopathy. Appearance of live Ascaris in the mouth and nose has been reported on rare occasions.

Some patients may excrete a metabolite which imparts an odor to urine, much like that which occurs after ingestion of asparagus. Crystalluria without hematuria has been reported on occasion, but has promptly subsided with discontinuation of therapy; while the etiologic role of thiabendazole has not been established, the possibility of crystalluria should be kept in mind. Transient leukopenia has been reported in a few patients, but the cause and effect relationship in these cases has not been established.

NOTE: In children weighing less than 30 pounds, clinical experience with thiabendazole for treatment of intestinal parasitosis has been limited. Thus, the benefits of this therapy should be weighed against the possibility of adverse reactions.

Supplied: Suspension, containing 500 mg per 5 cc, in bottles of 120 cc.

For more detailed information, consult your MSD representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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NASA Develops Sleep Analyzer

A sleep analyzer developed from technology originated by the National Aeronautics and Space Administration has been made available as a research device to United States medical institutions.

Three prototype models of the compact portable device have been built for research organizations by SCI Electronics, Inc., a subsidiary of SCI Systems, Inc., Houston. Developed for NASA by Dr. James D. Frost of Baylor University College of Medicine, this equipment will see its first use as an experiment aboard NASA's Skylab vehicle, scheduled for flight in 1973.

The quality of the sleep of a Skylab astronaut will be recorded continuously during his 28-day period in space by the sleep analyzer aboard, using electro-encephalogram and electro-occulogram signals. By combining and evaluating the EEG and the EOG inputs, the device provides a record of the "deepness" and hence the quality of the sleep of the subject it analyzes.

Rapid eye movements indicated by the EOG signals, coupled with the EEG indications of brain activity, may show that the patient is dreaming, is experiencing disturbed sleep, has just dozed off, or will soon awaken.

The three prototype devices now available include one just received by the University of South Carolina Medical School for use in sleep research with patients suffering from burns. The Galveston medical branch of the University of Texas has used an analyzer to study the sleep characteristics of victims of brain and head injuries.

The Veterans Administration Hospital, Oklahoma City, has the third sleep analyzer deployed on a 17,000-foot mountain peak on the Alaskan-Canadian border to study the sleep of subjects living and working at this altitude.

Its compact size, portability and reliability, at relatively low cost, have been cited as the principal advantages of the SCI sleep analyzer. The compact, portable system incorporates high reliability solid state electronic circuits, including an optional recorder. It can be used by the researcher in the laboratory, clinic, or patient's home.

Present models cost $5,200 each as contrasted with approximately $100,000 for a vastly more cumbersome unit of stationary equipment used to perform similar functions in monitoring sleeping subjects before this new technology was developed.

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hydroflumethiazide, 50 mg./reserpine, 0.125 mg./ protoveratrine A, 0.2 mg.

Brief Summary of Prescribing Information—9-9/22/69.
For complete information consult Official Package Circular.

Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or *bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in postsympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

Adverse Reactions: *Hydroflumethiazide:* Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
October 1971, Vol. XII, No. 10

ORIGINAL PAPERS

Mediastinoscopy: A Superior Alternative to Exploratory Thoracotomy?

PANDELI ANAS, M.D., CARLOS M. CHAVEZ, M.D.,
JACK RATLIFF, M.D., and J. HAROLD CONN, M.D.
Jackson, Mississippi

Mediastinoscopy is a relatively new method of gaining access to the mediastinal lymph nodes for exploration and biopsy. The authors discuss the technique used at University Medical Center in a series of 105 cases. They also present illustrative cases to stress the indications, complications, and results obtained with mediastinoscopy as a diagnostic procedure.

MEDIASTINOSCOPY IS a relatively new diagnostic method in the armamentarium of the thoracic surgeon, and as such, is undergoing a period of critical evaluation to determine its value and place among the accepted diagnostic procedures used at the present time. After the initial description by Rouviere of the pulmonary lymphatic drainage, several procedures have been used to gain access to the mediastinal lymph nodes for exploration and biopsy purposes. Diverse approaches have been employed, and among others, anterior mediastinotomy, lateral cervical mediastinal exploration and transbronchial subcarinal lymph node biopsy have been described; however, none has enjoyed the acceptance of mediastinoscopy.

Introduced by Carlens in 1959, mediastinoscopy represents an extension of the so-called scalene node biopsy. After the initial description by Carlens, an increasing number of publications testify to the popularity that mediastinoscopy is gaining as an adjunct in the diagnosis and management of intrathoracic diseases.

Stimulated by the preliminary success of mediastinoscopy as a diagnostic procedure, an initial effort was made by one of us (C.M.C.) to employ this method of diagnosis in 1966. Following a period of careful evaluation, this procedure has now become part of our preoperative work-up in patients with intrathoracic lesions. It is the purpose of this article to describe the technique of mediastinoscopy we used in a series of 105 cases, and present a few illustrative cases to stress the indications, complications, and results obtained with mediastinoscopy as a diagnostic procedure.

Mediastinoscopy can be performed under general or local anesthesia; our preference is for the latter. The patient is placed in supine position with the neck hyperextended. A 5 cm. long transverse incision is made just above the sternal notch. The subcutaneous tissue and platysma muscle are divided transversely and the strap muscles are separated laterally. The procedure to

From the Departments of Surgery, University Medical Center and Veterans Administration Center, Jackson, Miss.

this point is similar to a tracheostomy. Following this, the pretracheal fascia is incised below the thyroid isthmus and the trachea is cleared from the surrounding tissues both anteriorly and laterally, using blunt dissection. Figure 1 shows the anatomical relationships of mediastinal structures involved in mediastinoscopy.

The surgeon's index finger is then introduced posterior to the pretracheal fascia. It is very important to remain in the proper dissection plane where very little resistance is encountered (see Figure 2). The carina is reached easily by pushing the great vessel towards the sternum and away from the trachea. The paratracheal and retroaortic areas are carefully palpated on both sides.

The mediastinoscope is then introduced through the same plane for inspection of the above mentioned areas (see Figure 3). Although a special mediastinoscope (see Figure 4) is available, a straight-bladed laryngoscope can serve the same purpose. An assistant should be located at the right side of the patient, palpating his right radial pulse. Compression to the innominate artery is possible, due to excessive pressure of this vessel against the anterior chest wall with the mediastinoscope. Disappearance of the radial pulse indicates occlusion of the innominate artery by that maneuver, which also produces a decreased carotid blood flow on the right side.

A great deal of dissection can be carried out with a blunt-ended suction tip. Also, by using the suction tip, with some experience, the consistency of the tissues can be evaluated. Prior to obtaining any biopsy, the tissue is aspirated with a #20 long needle to avoid catastrophic bleeding from a major vessel. A punch biopsy can be then obtained with a long forceps, under direct vision. In general, no attempt is made to excise a lymph node in toto unless careful hemostasis can be accomplished, since persistent bleeding from its hilar artery may occur. After exploration and biopsy, the mediastinoscope is withdrawn and the wound is closed in layers, approximating the skin with subcuticular sutures.

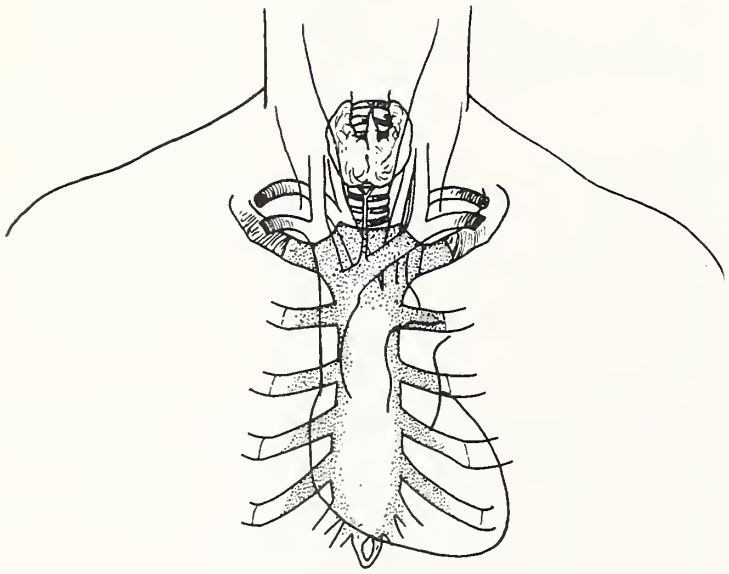


Figure 1. Diagrammatic representation of the anatomical relationships of the mediastinal structures.

COMPLICATIONS AND SAFETY

The experience now accumulated from more than 4,000 reported cases indicates that mediastinoscopy carries a complication rate of less than two per cent and the associated mortality is calculated at 0.3 per cent. There is a wide variety of complications that can be anticipated but these can be avoided if the principles of the technique are not violated.

The most common complication is a right pneumothorax. This can be treated by simple aspiration or chest tube insertion. In almost every case, the pneumothorax will respond to these measures and will not recur. Damage to the left recurrent laryngeal nerve or the azygos vein have been reported; likewise, injury to the esophagus is possible but extremely uncommon.

Significant bleeding due to puncture or inadverted biopsy from a major vessel can be a seri-

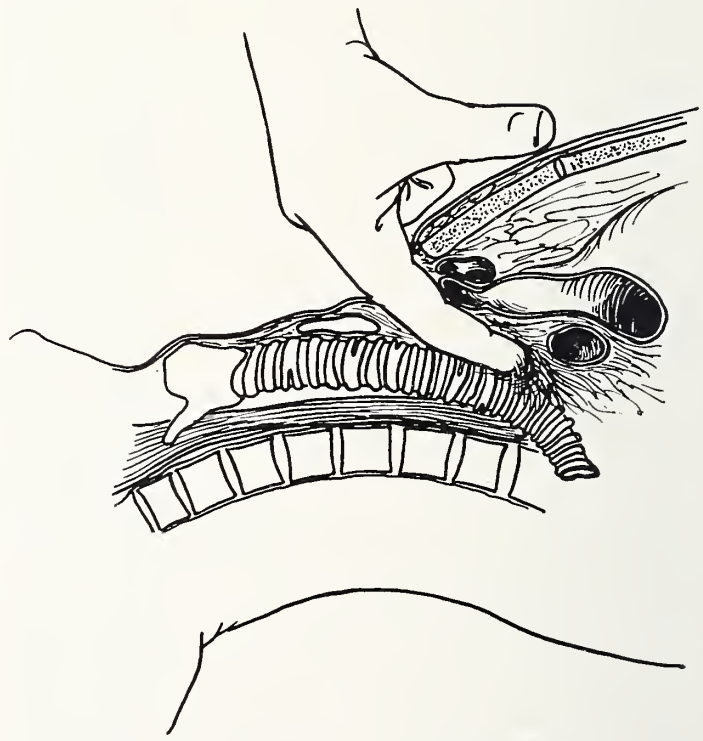


Figure 2. Technique of mediastinoscopy. Lateral view of mediastinal structures showing the index finger of the examiner in the pretracheal dissection plane.

ous complication. Tamponade with gauze will stop most needle punctures but immediate thoracotomy will be required for major injuries. Although this complication is extremely rare, it is

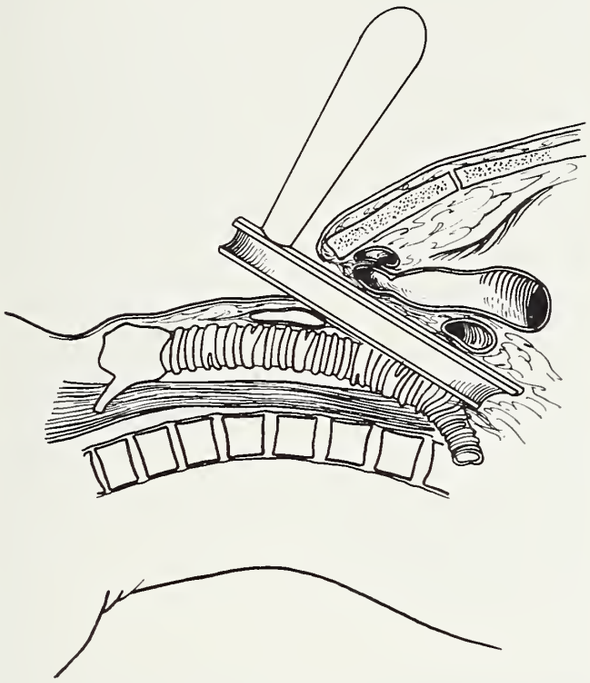


Figure 3. Introduction of the mediastinoscope for inspection of the subcarinal area.

very important that the person performing a mediastinoscopy be able to deal with it if it occurs. The superior vena caval syndrome is not a contraindication for mediastinoscopy. It should be performed, however, with added care, to avoid excessive bleeding.

A potential hazard associated with this procedure is the implantation of tumor cells along the dissection plane of the mediastinoscopy. Three cases with skin implantation have been reported thus far, but the overall incidence is not different from that following any other biopsy procedure.

Despite the fact that a wide variety of potential complications do exist, the morbidity of mediastinoscopy is minimal. It is as safe as a scalene node biopsy, but on the other hand, is a more informative procedure.

ILLUSTRATIVE CASES

Case No. 1: G. S., a 68-year-old white male was admitted with the chief complaint of hoarseness and gradual weight loss. A chest x-ray (see Figure 5a) revealed, in addition to fibrotic and emphysematous changes, irregular nodular infiltrations extending peripherally from the right hilar

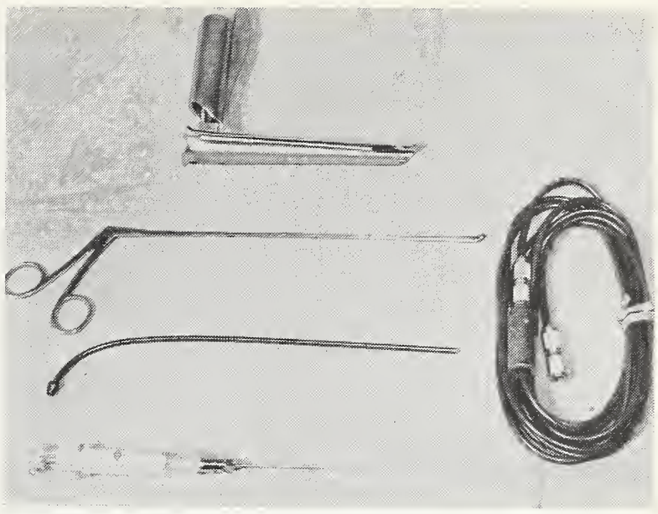


Figure 4. Instruments used for mediastinoscopy, including the Carlens mediastinoscope, biopsy forceps and suction tip. A long needle is also depicted, which is used for aspiration purposes.

shadow, suggestive of neoplastic disease. The sputum cytology and bronchoscopy were not diagnostic and direct laryngoscopy revealed left vocal cord paralysis. Mediastinoscopy was performed and several firm lymph nodes felt bilaterally, the biopsies of one of which showed squamous cell carcinoma (see Figure 5b). Comment: Mediastinoscopy in this case provided the diagnosis and, in proving the patient to be inoperable because of bilateral involvement, avoided an unnecessary thoracotomy. This patient was subsequently treated with radiotherapy.

Case No. 2: L. V., a 17-year-old white female was found to have bilateral dense, well circumscribed anterior mediastinal masses following a routine chest x-ray (see Figure 6a). She was in an excellent state of health. Clinical and laboratory findings were suggestive of a lymphoma and positive tissue diagnosis was obtained by means of mediastinoscopy and biopsy. The superior mediastinal masses were easily accessible and biopsies of these revealed nodular sclerosing type of Hodgkin's disease (see Figure 6b). Her postoperative course was uneventful and she received Cobalt radiotherapy starting on the second postoperative day, to which she responded with remarkable radiographic improvement. One year later she underwent exploratory laparotomy and splenectomy which verified our diagnosis of stage I-A Hodgkin.

DISCUSSION

Diagnosis of intrathoracic lesions and determination of resectability of bronchogenic carci-

noma are the most common indications for mediastinoscopy.

Exfoliative cytology and bronchoscopy will yield a positive diagnosis in approximately 60 per cent of cases of bronchogenic carcinoma. Scalene node biopsy is presently reserved only for patients with palpable nodes. Mediastinoscopy has been found to yield positive findings in 40 per cent of all cases, and in 10 per cent is the only method which provided the diagnosis. This can be considered a high diagnostic accuracy.

Certainly, it is very important to realize the limitations of mediastinoscopy. With this procedure only the posterior bronchomediastinal lymphatic trunk can be evaluated; that is, the peribronchial, the anterior subcarinal and the paratracheal nodes. The posterior subcarinal nodes, the anterior mediastinal and the retroaortic nodes are not accessible. Mediastinoscopy is considered a method for evaluating the extent of lymphogenous spread of the disease to the mediastinal areas; however, due to the limited access with this method, the spread of the lesion to other areas cannot be fully determined.

False negative results with mediastinoscopy are not uncommon. Some of these are related to inexperience and, therefore, rather timid mediastinal explorations. When a positive lymph node is biopsied, the patient with bronchogenic carcinoma, for all practical purposes, is not a candidate for curative resection. On the other hand, the place of palliative resection for bronchogenic carcinoma is limited. It is also a known fact that more than 50 per cent of all cases of bronchogenic carcinoma have lymph node metastasis at the time of diagnosis.

The purpose in using mediastinoscopy rather routinely is to discover the cases, which by previous standards, are considered operable, but at thoracotomy are found to be nonresectable. The experience of those using mediastinoscopy in large scale is that their chest exploration rate has decreased, while their resectability rate has increased significantly to 90 per cent.

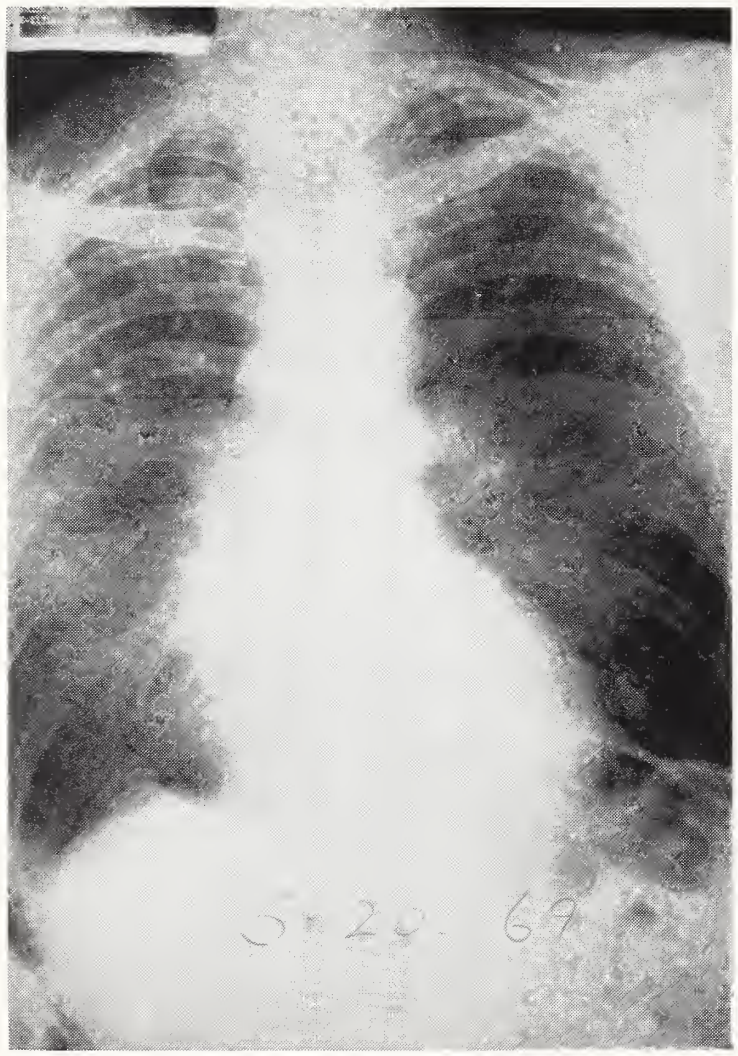


Figure 5a. Case 1. PA chest x-ray reveals right hilar prominence with distal atelectatic changes, suggestive of bronchogenic carcinoma.

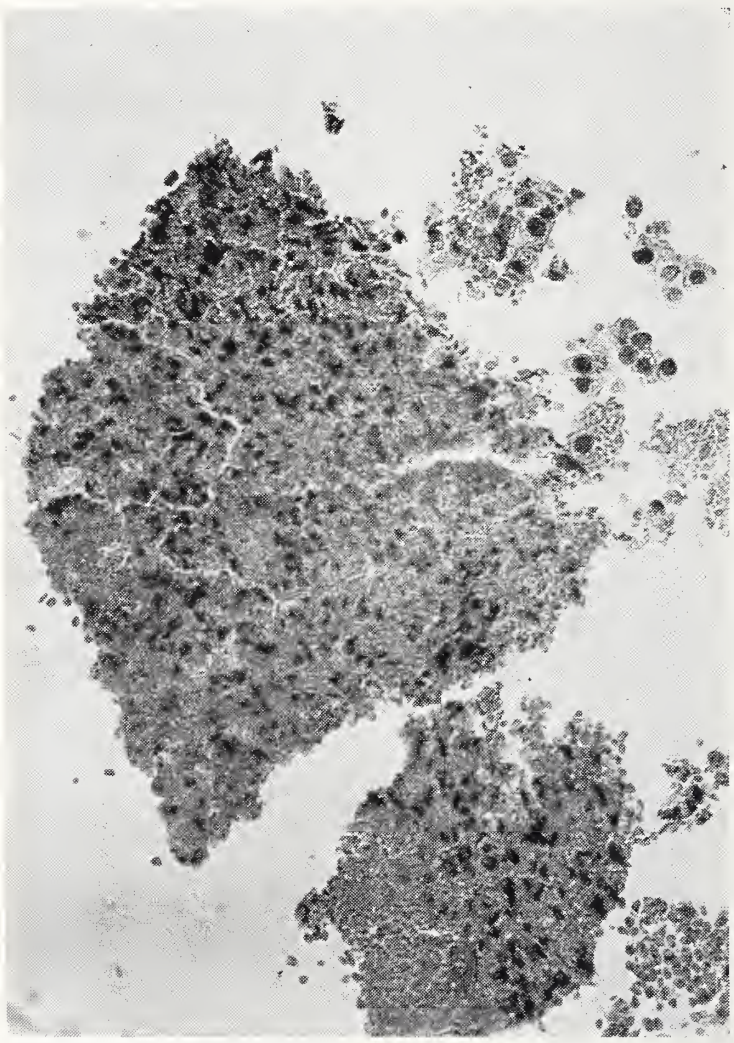


Figure 5b. Photomicrograph of Case 1. Diagnosis: Bronchogenic carcinoma. Conventional workup including bronchoscopy were not diagnostic.

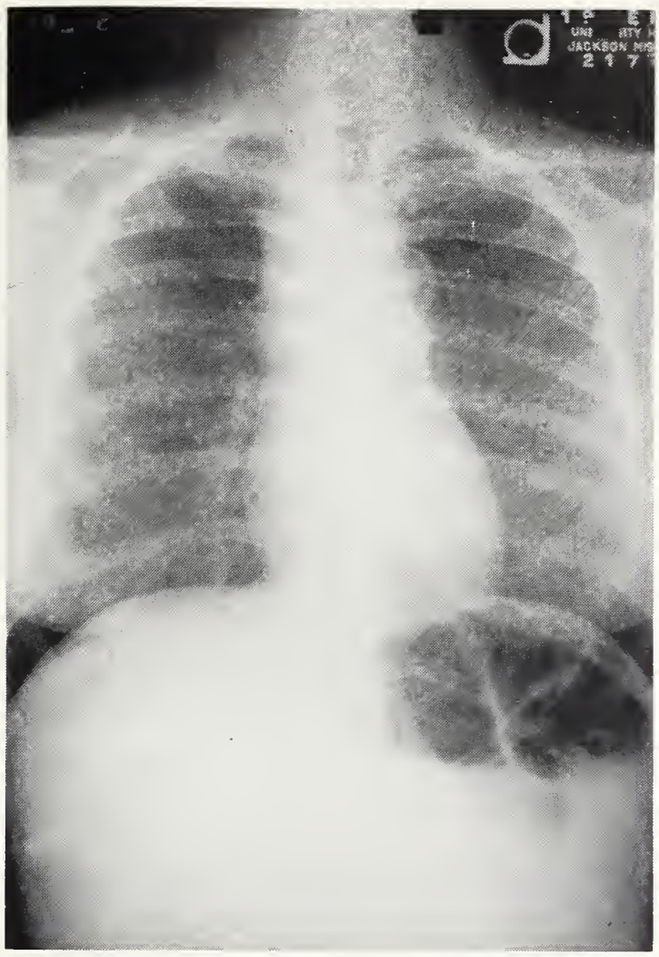


Figure 6a. Case 2. PA chest x-ray showing bilateral involvement of the upper mediastinum.

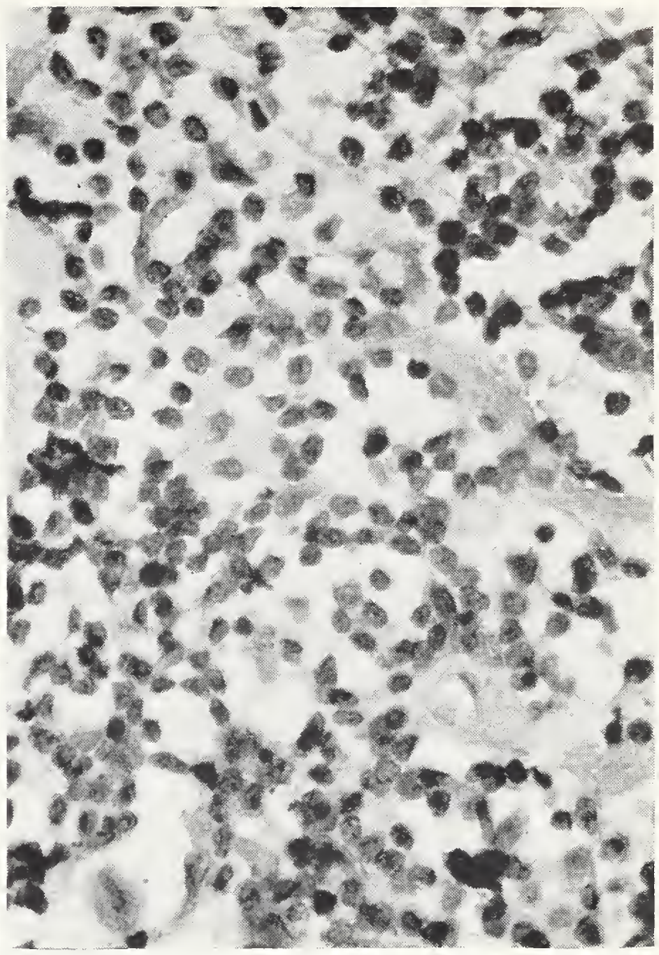


Figure 6b. Photomicrograph of Case 2. Diagnosis: Hodgkin's Disease.

Thirty per cent of presumably operable patients are found to have positive mediastinoscopies. Most of these are rejected for surgery because of contralateral positive lymph nodes, tumor fixation or microscopic diagnosis of oat-cell carcinoma. Mediastinoscopy appears to be a quite safe procedure compared to exploratory thoracotomy which has no therapeutic value to the patient and carries a significant morbidity and mortality. Mediastinoscopy has an extremely high diagnostic value in diffuse nonmalignant intrathoracic diseases. Its diagnostic yield approaches 100 per cent in sarcoidosis.

The surgical approach used for mediastinoscopy has been used for a variety of purposes. Carlens has used the mediastinoscope to insert pacemaker electrodes to the atrium. Transcervical thymectomy can also be performed through this type of incision for myasthenia gravis or for cases of hyperparathyroidism where neck exploration was inadequate to remove parathyroid (parathymic) adenomas.

SUMMARY

Mediastinoscopy has emerged as a very informative procedure in evaluating patients with bronchogenic carcinoma. Our experience with 105 cases has been very rewarding in the diagnosis and selection of patients prior to surgery. It is associated with a low complication rate and provides a high diagnostic yield and a fairly accurate assessment of resectability. In diffuse intrathoracic lesions mediastinoscopy offers a higher incidence of positive results than any other diagnostic procedure. ★★★

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SAVE OUR MERCURY!

The pollution problem has become critical. Last week, a shipment of 5,000 gallons of mercury was en route to a manufacturer. At a stop along the way, a railway freight inspector was checking the tank car when he carelessly dropped his lunch, consisting of a tuna fish sandwich, into the inspection port.

It was later discovered that the mercury was hopelessly contaminated, testing almost 5 ppm tuna. Experts say that this is a dangerous and unacceptably high level of tuna pollution, rendering the mercury useless.

Cervical Spondylosis

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In the last 22 years the neurological entity, known as cervical spondylosis, has been elucidated. It is a common cause of neck pain and weakness in the arms and legs. The symptomatology depends upon the development of cervical cord compression, cervical nerve root compression or a combination of both. The symptoms are produced by interference with the ascending and descending long tracts and cervical root compression. The natural history of the disease is chronicity without evidence of symptom progression, although in individual cases a rapidly progressive course can be seen. The author discusses various modalities of surgical and conservative therapy.

SINCE 1948 the entity, cervical spondylosis, has been recognized and defined. This was chiefly through the writings of two English neurologists, Lord Russell Brain and Marcia Wilkinson. They defined the syndrome and related it to the pertinent anatomy and physiology. Therefore, a common cause of pain, weakness and disability of middle-aged and elderly people has been increasingly more successfully dealt with.

The generalist and internist should expect to see patients with this condition many times a year. Since early recognition can in some cases prevent progression (and even fatal complications in the case of cervical spine injuries[8]), it is useful to bring to the attention of the non-neurologic members of the medical community the salient features of this condition. In order to understand the clinical symptomatology, it is first necessary to understand the anatomy and physiology of the cervical spine and to consider the effects of aging upon it.

The cervical spine like the lumbosacral spine is the site of many complex movements associated with everyday life. This is in contrast to the thoracic spine which is normally very rigid with little potential for flexion, extension, or torsional movements. Much of the stability of the cervical spine is due to the anterior and posterior spinal ligaments. The anterior ligament descends on the anterior surfaces of the vertebral bodies and discs, and the posterior ligament down the spine on the posterior surfaces forming the flat anterior boundary of the cervical spinal canal. Also adding to the stability of the cervical spine are the various layers of neck musculature.

From the Mid-South Neurological Clinic, Memphis, Tenn.

The flexibility of the cervical spine is very much dependent upon the intervertebral discs. The outer portion of the circular discs is formed by the fibrous annulus fibrosis. Centrally located in the disc is the pearly white mucopolysaccharide nucleus pulposus which distributes shocks coming from various directions evenly to the annulus and vertebrae which the nucleus is between. It is largely oval in shape and bound to the periosteum of the vertebrae above and below. No disc exists between the first cervical vertebra—the atlas—and the base of the skull, or between the second cervical vertebra—the axis—and the atlas.

The spinal cord leaves the skull through the foramen magnum and descends through the cervical spinal canal. The cord is roughly oval in shape. The canal through which it passes is tri-

angular in shape. The base of this triangle is located anterior to the cord, being formed as mentioned above by the vertebral bodies and discs with the posterior spinal ligament binding the discs and bodies together. The laminae meet posteriorly forming the lateral walls and the apex of this triangle. From the posterior funiculus of the cord on either side exit the dorsal sensory rootlets which form the dorsal root. Ventrally motor rootlets leave to form the ventral nerve root. The dorsal and ventral roots unite to form the cervical nerve root which exits with a dural root sleeve investment[7] through the intervertebral foramen.

INTERVERTEBRAL FORAMINA

The intervertebral foramina are roughly oval in shape, the anterio-medial margin—the neurocentral articulation—being formed by the vertebral body and intervening discs, the posterior-lateral margin being formed by the articulation of the inferior articulating facet of the vertebra above and the superior articulating facet of the vertebra below. Vascular radicles from the vertebral arteries enter on the nerve root to supply the anterior spinal artery. Ordinarily the existing nerve root occupies about 20 per cent of the cross sectional area of this foramen.[9] The dentate ligaments anchor the cord in position in the canal laterally. These fix the cord rather tightly in place and prevent movement of the cord in the canal in the anteroposterior diameter. Posteriorly the ligamenta flava extend from the middle of the antero-inferior surface of the lamina above to the superior margin of the lamina below.[15]

To return for a minute to a consideration of the intervertebral foramina, it should be noted that the first two cervical nerve roots exit behind the respective vertebral articulating surfaces. The last five cervical nerve roots exit between what are, in fact, two articulations. As mentioned above, the posterior articulation is composed of the facets. The anterior boundary of the intervertebral foramen is formed by the neurocentral joint of Lushka.

With this understanding of the anatomy and physiology, it is now possible to discuss the pathophysiology and predict the symptomatology of cervical disc disease.

Before beginning a discussion of cervical spondylosis, it is perhaps useful to discuss a syndrome which is distinct from cervical spondylosis. This is cervical nuclear herniation. As mentioned above, the central part of the disc is called the nucleus pulposus. It is mucopolysaccharide, semi-liquid, and resilient. It is confined to the center of the disc by the annulus fibrosis and the anterior and posterior spinal ligaments. The posterior spinal ligament does not extend the entire distance laterally on the posterior surface of the disc and it is possible that the most central fibers of the posterior spinal ligament are the weakest. The nucleus pulposus in the cervical area is thought to be under pressure in the recumbent position of approximately 32 pounds per square inch. In the upright position this pressure increases to over 100 pounds per square inch and in exceptional circumstances can exceed 300 pounds per square inch.[8] When trauma occurs in the course of employment, accidents or sports activities, the pressure may become so great that the nucleus pulposus is herniated into the spinal canal or nerve root exit area in the region of the intervertebral foramen.

There are three common sites of herniation—a dorsal herniation through the most central fibers of the posterior spinal ligament, a lateral herniation into the anterior-lateral portions of the spinal canal, and an intra-foraminal herniation in the region of the root exit zone. It has been estimated that the average volume of the herniated cervical nucleus pulposus is 0.21 cc. with a diameter of 7 mm.[3] The AP diameter of the cervical canal is approximately 17.9 mm.[7] where the average AP diameter of the cervical cord is 10 mm.

CORD COMPRESSION

It is infrequent but possible for a completely dorsally herniated nucleus pulposus to cause symptoms of cord compression with weakness or paralysis of the legs and bowel or bladder symptoms. Likewise, a lateral protrusion could cause lateral cord compression with the Brown-Séquard syndrome of ipsilateral motor weakness and contra-lateral pain and temperature loss. Most frequently the discs herniate intra-foraminally from an extreme lateral position where the fibers of the posterior spinal ligament are sparse, if not absent. Such a nuclear herniation produces an appropriate root syndrome with weakness, cervical pain, muscle spasm, and sensory loss. Findings of muscular wasting, decreased reflexes and dermatome sensory loss are concomitant of such herniation. Infra-foraminal rupture is the type of herniation seen in young people.

The problem in cervical spondylosis is different. This is a disease of middle-aged and elderly people and is related to degenerative changes, although trauma may play an important part.[5] It is thought that in the normal course of aging there is a loss of water content from the annulus fibrosis

and nucleus pulposus, the rate of desiccation being constant until approximately the fifth decade when the desiccation of the nucleus pulposus greatly outstrips that of the annulus fibrosis.[8] When this occurs there is narrowing of the intravertebral space with the result that there is bulging of the posterior and anterior spinal ligaments and degenerated discs producing posterior encroachment on the cervical canal.

It is thought that the bulging of the disc and the loosening of the spinal ligaments cause instability of the spine and abnormal movements. These abnormal movements in turn stimulate the growth of bone called exostoses which protrude posteriorly and may cause bony compression of the spinal cord. It is known that usually these osteophytic dorsal protrusions do not compress the spinal cord. However, with extreme bony growth patients have signs of cord compression. The diameter of the cervical canal is reduced by 3 mm.[7] on the average in these cases. This is true even in portions of the cervical spine where the bony disc is not found. It is, therefore, thought that this condition is more likely to arise in persons whose cervical canal is congenitally small.

OTHER FACTORS

As mentioned above, the anterior and posterior margins of the intervertebral foramina are formed by joints which are subject also to abnormal movements produced by instability of the spine. When bone growth occurs in these joints there results a reduction in the cross sectional area of the intervertebral foramina,[14] therefore rendering the exiting nerve root and the entering radicular artery vulnerable to compression. Degenerative hyalin thickening of the above mentioned dural root is thought to produce traction on the exiting nerve and thought possibly able to contribute to the development of radiculopathy.[5]

Post-mortem examinations on patients with cervical spondylosis show compression. Specimens show markedly protruding posterior osteophytes which have gouged out concave indentations in the spinal cord, these indentations corresponding exactly to the osteophytes.[5]

Although posterior osteophytosis is thought by many to be the most likely factor in the production of myelopathy, other theories have been proposed. Some feel that when an osteophyte pushes backward and impinges upon the spinal cord, it is restrained from posterior movements by the dentate ligaments with the result that the main pressure is exerted at the site of attachment of the dentate ligament to the spinal cord, thus producing degeneration in the descending cortical spinal tracts.[2] It has also been proposed that compression of the incoming radicle from the spinal artery produces ischemia in the distribution of the anterior spinal artery and degenerative changes due to ischemia of the cord rather than mechanical compression.[13] It has been noted both in post-mortem material and in radiographs that upon extreme extension of the neck there is bulging anteriorly of the ligamenta flava and that these ligaments produce trauma to the very vulnerable spinal cord with resulting degeneration.[15]

CORD DEGENERATION

In any given patient one or more of these factors may be operative in producing cord degeneration. If one examines pathologically the spinal cord at the site of cord compression and also above and below it, one can find evidence of degeneration in the ascending and descending long tracts.[8] This corresponds to the weakness in the lower extremities along with sensory changes and also sphincter disturbances.

In summary then, the predicted symptoms of the degenerative changes produced by cervical spondylosis would be upper extremity radicular symptoms produced by interference with the cervical nerve roots, lower extremity symptoms due to interference with the long tracts by damage to the spinal cord, and a third syndrome of both upper extremity radicular symptoms and lower extremity findings wherein both roots and cord were affected simultaneously.

CLINICAL SYMPTOMATOLOGY

Etiological features.[9] In summarizing the experience of 111 patients, it was found that men were affected more than women in the ratio of 2.4:1. The average age of onset was 53 years, and in 63 per cent of the patients the first symptoms occurred over the age of 50. Forty-seven per cent gave a history of neck trauma either resulting from accidents or in the course of occupations involved in carrying heavy weights on the head or shoulders. In discussing the mode of onset of the symptoms, 36 per cent mentioned the first complaint was pain, numbness, tingling, or weakness in a root distribution. In another 27 per cent the first symptom was progressive weakness of one or both lower limbs, and in six per cent the upper limbs and lower limbs were involved simultaneously. In six per cent trauma was related to the onset of symptoms. In the remaining patients the presenting symptom was sciatic pain, pain in the chest, or shoulder girdle pain.

In patients with radicular disease the symptoms were due to a compression of a nerve root

or roots where pain or paresthesias were either generalized or of root distribution. There was also weakness or clumsiness in one or both hands and neck stiffness and pain. These symptoms were acute, subacute, or insidious in onset. When the onset was acute it was usually as the result of trauma and only one nerve root was usually affected. When the onset was subacute or insidious, the most common complaint was burning or tingling radiating down the arm, most commonly into the middle ring and index finger. The pain was most severe at night and tended to improve within a few hours of waking.

When cord compression occurred the most common symptom was difficulty in walking or weakness of one or both lower limbs. Weakness of one or both legs occurred in 58 per cent and difficulty walking in 24 per cent, this being usually due to spastic weakness of both lower limbs.

Forty-three per cent of the patients complained of sensory disturbances in the lower limbs. Twenty-nine per cent gave symptoms of precipitancy, frequency, and hesitancy. This was in no patient a presenting symptom, and when urinary incontinence occurred a severely damaged cord was associated.

Physical signs. Muscle wasting occurred in 62 per cent of the patients and was most severe in the upper extremities and tended to become obvious when multiple roots were involved. Generally involved were either the arm, the hands or both the hands and arms. Wasting was most marked in the hands (39 per cent) and in the shoulder girdle (16 per cent). Muscle weakness was found in the upper limbs in 90 per cent of the patients. Fasciculations occurred in 27 per cent. Fasciculations can occur in both upper and lower extremities.[11]

When the lesion is purely radicular, the segmental reflexes are diminished or occasionally completely lost. When cord compression takes place, the deep tendon reflexes in one or both upper extremities are often exaggerated. Thirty-one per cent of the patients had impairment of sensation in one or more of the cervical dermatomes and 15 per cent (all of whom had cord compression) had a sensory level.

The neck movements were limited in 42 per cent and in 21 per cent this limitation was painful. It was frequently seen when there was radicular involvement. The pain was referred to the shoulder with the result that the shoulder was held immobile with secondary degenerative changes.

Examination of the spinal fluid in cervical spondylosis usually revealed the pressure to be normal. There was evidence of block in approximately 16 per cent and in 28 per cent of the patients the protein in the spinal fluid was over 50 mg. per cent and in three patients it was over 100 mg. per cent.

Radiological changes.[14] The radiological changes which are seen in cervical spondylosis include narrowing at the intervertebral spaces at one or more levels and osteophyte formation or "lipping" on lateral views. There is straightening of the cervical spine with abnormal movement seen with dynamic views. On oblique views, which should be routine in the analysis of these patients, more or less obliteration of the intervertebral foramina can be seen. Many of these changes are seen normally in people over the age of 50. The radiological changes are not of great significance, if no radicular or cord compressive symptoms are present. When this condition is suspected and a cervical myelogram with pantopaque has been performed, indentations and obstructions to the flow of the pantopaque are often seen corresponding to the site of the posterior osteophytes or bar formation seen on plain films. Those changes are noted on the AP view. In the lateral view indentations in the pantopaque column corresponding to the osteophyte can be seen.

DIFFERENTIAL DIAGNOSIS

Cervical spondylosis is the most common cause of weakness in the legs or difficulty in walking in the middle-aged or elderly groups.

Multiple sclerosis must be considered in the differential diagnosis of cervical spondylosis, but it tends to begin in a much younger age group—the first symptoms usually appearing in the second or third decades. It tends to occur with remissions and exacerbations of neurological deficits, and urinary symptoms tend to occur early in multiple sclerosis and late in cervical spondylosis. Abdominal reflexes are frequently exaggerated in cervical spondylosis and are usually absent in multiple sclerosis. Symptoms involving structures higher than the spinal cord such as the cranial nerves are frequent in multiple sclerosis and uncommon in cervical spondylosis which involves the structures below the foramen magnum exclusively.

Motor neuron disease or amyotrophic lateral sclerosis can produce weakness and wasting in the upper extremities and spastic weakness in the lower extremities. In addition, the disease tends to affect similar age groups. Fasciculations may be present in both conditions. However, in cervical spondylosis the fasciculations tend to be

limited to one or two nerve roots in the cervical area, whereas in amyotrophic lateral sclerosis they tend to be widespread. In addition, pain which is a prominent feature of cervical spondylosis is absent in amyotrophic lateral sclerosis.

Syringomyelia can be a difficult differential because it may occur in the same age group and cause a cervical arthropathy. However, in syringomyelia the wasting of the hand muscles is usually more marked than in cervical spondylosis and there is a characteristic disassociated sensory loss in that the posterior column sensations are frequently intact when the pain and temperature sensations are lost. Burns of the hands are frequent because of the loss of pain and temperature sensation. Because the brain stem is frequently involved with the syrinx cavity, bulbar signs and symptoms are common.

Extradural tumors affecting the cervical cord can produce a clinical syndrome similar to cervical spondylosis, but in this condition the spinal fluid protein is characteristically high. The myelographic picture is much different and the progression of symptoms is more relentless than in cervical spondylosis. Subacute combined degeneration of the cord resulting from pernicious anemia can produce spastic weakness in the lower extremities suggesting the myelopathy of cervical spondylosis. However, there is the presence of histamine fast achlorhydria and the characteristic megaloblastic anemia.

Rheumatoid arthritis affecting the cervical spine can produce pain and limitation of motion of the neck. However, the x-ray findings are much different and usually affect the levels of C2, 3, and 4, whereas the change of cervical spondylosis more commonly affects levels 5, 6, and 7. In rheumatoid arthritis affecting the cervical spine there is little osteophytosis and there is erosion of the vertebral plates and subluxation of the vertebrae.

NATURAL HISTORY

The course of cervical spondylosis is subject to considerable variation. It has been stated that the natural history of the disease ordinarily is one of nonprogressive disability.[10] A progressively deteriorating course is exceptional. If symptoms of myelopathy are not present when the patient is first seen, they are not likely to develop. In one series 106 patients were followed for an average of 50.9 months.[9] Seventeen of these patients died and in eight of them cervical spondylosis was directly related to their demise. Four died following an injury involving the cervical spine and three within a short time of operation. One died of bronchopneumonia six months after operation. Ninety-one patients were followed for a period of 12 months or more. Thirty-nine per cent were treated with physical therapy only, and of these 60 per cent improved. Thirty-four per cent showed no significant change. Six per cent were worse. Thirty-five patients were treated with collars and 46 per cent were improved and 48 per cent were unchanged and six per cent were worse. Twenty-one patients received some type of operative procedure and 57 per cent showed some improvement. Twenty-four per cent were unchanged and 19 per cent were worse.

Various modalities of physical therapy have been advocated. Bed rest with traction when there are no signs of cervical compression frequently produces relief of acute symptoms. This can then be combined with long periods during which neck exercises are practiced, the strengthening of the cervical muscles aiding the long term benefit of the symptoms. Relief is sometimes obtained through the use of a plaster of paris collar. The use of this collar, and when removed, the use of neck strengthening exercises can be of benefit.

SURGICAL THERAPY

Various modalities of surgical therapy have been advocated. In one series of 49 patients who had laminectomy with partial bilateral facetectomy when the nerve roots were compressed, 74 per cent improved, eight per cent remained unchanged, six per cent became worse, eight per cent died, and two were lost to follow-up. Sixty-one per cent improved sufficiently to allow them to return to work without physical limitation.[12] The criteria for operation were: (1) neurological deficit caused by compression of the cervical spinal cord; (2) nerve root compression; and (3) both 1 and 2. In exercising these criteria it is implied that conservative measures failed to relieve the symptoms.

An anterior approach involving renewal of the degenerated disc and osteophytes followed by interbody fusion with a bone dowel is said to have relieved 90 per cent of all symptoms whether the operation was performed for radicular or myelopathic symptoms. This seems to be the favored approach among neurosurgeons at the present time for cervical spondylosis.[16]

CONCLUSIONS

1. Cervical spondylosis is a common disease of the middle-aged and elderly.

2. Symptoms are caused by degenerative changes in the intervertebral discs producing infringement upon the cervical nerve roots, spinal

cord, or both by the bulging of the degenerative disc.

3. The course is one of prolonged non-progressive disability unless trauma produces acute and serious complications.

4. Surgical intervention may be required when progression of cord or radicular symptoms are taking place. ★★★

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SHUTOUT

Here lie the bones of dear old Miss Jones,
A spinster afraid of life's terrors.
She lived an old maid and she died an old maid,
No hits, no runs, no errors.

Dr. Anson Gordon Smythe: Member First Mississippi State Board of Health

BEULAH M. D'OLIVE PRICE
Corinth, Mississippi

In a few years the Mississippi State Board of Health will observe its centennial. It seems fitting that further research be done on those men who, in 1877, were the first members of that board. Among them was Dr. A. G. Smythe of Baldwyn.

Anson Gordon Smythe was born in York District, South Carolina on Aug. 22, 1816.[1] He was the son of Daniel Smythe who served in the war of 1812 and he was the grandson of James Smythe who served in the American Revolution. The great-grandfather of A. G. Smythe was Henry Smythe of Oxford, England, who emigrated to Philadelphia where he died in 1765.[2]

The parents of A. G. Smythe moved from South Carolina to Alabama, then to Carroll County, Mississippi. There the father, Daniel Smythe, died in 1868. He was both a farmer and a blacksmith.[3]

A. G. Smythe studied medicine in the office of Dr. Cross at Lexington, Mississippi, and attended lectures in New Orleans. He located at Bethany (Brice's Cross Roads) near Baldwyn in 1842. That same year he was married to Caroline Humphreys. Their only child, Dr. A[ndrew] J[ackson] Smythe was born February 29, 1856.[4] He was graduated from Bellevue Hospital College in 1881, after which he practiced at Bethany a number of years. In 1878 he had married Miss Emma Richey of Lee County. They had two sons and four daughters.[5]

Some ideas of Dr. A. G. Smythe's personality, appearance and varied interests may be obtained from information furnished by a descendant:[6]

> He had a quick temper and was very particular in his dress and speech and manners. He was practicing medicine before the Civil War. He kept batch for awhile, had a separate office. I now have the straight ladder back chair that he handmade of hickory wood and used in his office. He did a little oil painting and some cabinet making. He also wrote deeds and other legal papers to accommodate people that lived in that area.[7]

The author, respected Mississippi historian, gives a brief biography and professional sketch of Dr. Anson G. Smythe of Baldwyn. Among his most distinguished accomplishments were membership on the first Mississippi State Board of Health and the first recording of the prevalent diseases of the people in the First Congressional District.

Family tradition has it that Dr. A. G. Smythe practiced medicine in Alabama before moving to Mississippi and that he delivered the first white child born in a certain valley there [perhaps in Calhoun County].[8]

Dr. Smythe helped take care of the wounded from the battle of Brice's Cross Roads near Baldwyn, and other battles in the area. He was a Baptist and he and his wife were both members of Corona Grange which was at the settlement of Corona, south of Bethany.[9]

The house Dr. A. G. Smythe lived in at Bethany is still standing but has been quite changed. It is on the west side at the crossroads and just north of the village store. Originally there was a porch across the front and two front rooms separated by a hall. Two or three back rooms formed an "L" shape. Two later Smythe homes were destroyed: one by fire and one by tornado, and only a few of Dr. A. G. Smythe's possessions were preserved. These include a chair, some books, and some small mementoes.[10]

When the first Mississippi State Board of

Health was formed in 1877, Dr. A. G. Smythe, a member, was asked to prepare a "Report on the Prevailing Diseases of the First Congressional District." This paper was printed in the first annual report of the board, December 1877.[11]

Before writing the article Dr. Smythe had sent inquiries to doctors in the district asking for their observations on the cause, treatment and fatality of diseases but he got little response. He, therefore, could only rely on his own experiences and observations for his report which he limited to his practice in Lee and Prentiss Counties.[12]

Dr. Smythe stated that "A large proportion of the endemic diseases of the country embraced in this report are the direct effect or indirect result of the so-called malaria."[13] He said that area cases were generally mild which he felt was due to the fact that streams were few. He felt that in wetter areas "the frequency and gravity of the prevailing type of fever increases. . . ."[14] He thought that with proper drainage of the land the greater part of the malarial diseases in the higher part of the district might be prevented.[15]

Dr. Smythe believed that the main reliance in the treatment of "all types of malarial fever is in some of the preparations of cinchona. . . ."[16] He observed that recovery in all moderate cases was more rapid without the use of "cathartics or mercurials."[17]

An epidemic of dysentery in the summer of 1857 was mentioned by Dr. Smythe in which 10 per cent of all the cases were fatal. Both races were affected but the mortality was confined to the white race and with only one exception to women and children. Of the children who died "nearly all were females."[18]

According to Dr. Smythe "True typhoid or enteric fever is not, nor has it ever been here . . . it can only originate where the cause exists, and the cause is not here, nor is it likely to be here." He also said, "Your reporter is not prepared to admit the existence of the so-called typho-malarial fever."[19]

Over a period of 18 years Dr. Smythe said there had been few cases of diphtheria, but with these there was a fatality of 50 per cent of the grave cases.[20] Salicylic acid was given an edge of preference over other remedies for the disease, though he said, "the treatment has not been satisfactory or successful."[21]

One case of "Elephantiasis Arabum" and a few cases of "Keloid" were reported.[22]

Dr. Smythe called to mind a very grave and fatal form of "phlegmonous erysipelas" in what is now Prentiss County, south and east of Booneville, in February, March and April of 1845. It carried with it "terror, great suffering and death in almost every house it visited. . . ."[23] One third of those attacked fell a prey to the epidemic. "The mortality was principally among women and girls, no adult males having died of the disease."[24]

In conclusion Dr. Smythe reported that for the past three years, in spite of a rather large amount of sickness, the death rate had been remarkably low. This statement was made by personal observation. As yet Mississippi had "no mortuary statistics or system of [death] registration."[25] The doctor hoped these would be available in the early future.[26]

Dr. Anson Gordon Smythe died July 2, 1884, and is buried in Gaston Cemetery about one and one-half miles southwest of Bethany. Nearby is the grave of his wife, Caroline Humphreys Smythe, who died in 1876.[27] ★★★

716 Fifth Street (38834)

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5. *Ibid.*
6. Miss Emma Smythe of Baldwyn, a granddaughter of Dr. A. G. Smythe.
7. *Ibid.*
8. *Ibid.*
9. *Ibid.*
10. *Ibid.*
11. *First Annual Report of the Mississippi State Board of Health.* Dec. 1877 (Jackson, Miss. Power and Barksdale, State Printers). Dr. Smythe's report is on pages 135 through 138.
12. *Ibid.* pp. 135-136.
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14. *Ibid.* p. 136.
15. *Ibid.* p. 137.
16. *Ibid.* p. 136.
17. *Ibid.* p. 136.
18. *Ibid.* p. 137.
19. *Ibid.* p. 137.
20. *Ibid.* pp. 137-138.
21. *Ibid.* p. 138.
22. *Ibid.* p. 138.
23. *Ibid.* p. 138.
24. *Ibid.* p. 138.
25. *Ibid.* p. 138.
26. *Ibid.* p. 138.
27. The author has seen these graves.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Nov. 28-Dec. 1, 1971, New Orleans, Annual Convention, June 18-22, 1972, San Francisco. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

STATE AND LOCAL

Mississippi Academy of General Practice, Annual Meeting, July 13-15, 1972, Biloxi. Miss Louise Lacey, Executive Secretary, P.O. Box 1435, Jackson.

Mississippi State Medical Association, 104th Annual Session, May 8-11, 1972, Biloxi. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Joel L. Alvis, 714 N. State St., Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Second Wednesday, April and First Wednesday, November, 2:00 p.m., Clarksdale. Glenn L. Wegener, 1967 Hospital Drive, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. John G. Downer, 110 Tchula St., Lexington, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. A. Robert Dill, 1001 Main Street, Columbus, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Robert Donald, Box 1351, Pascagoula, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie Street, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday, January, April, July, and October, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.

Radiologic Seminar CXI: Post-Traumatic Pulmonary Embolism

ROBERT P. HENDERSON, M.D.
Jackson, Mississippi

THE PATIENT ADMITTED with multiple injuries representing a high risk case to develop pulmonary thrombo-embolism. In the usual high-speed motor accident there often is an associated chest injury as well as pelvic or lower extremity injury. Symptoms and signs such as intercostal tenderness, pleuritic pain, friction rub, rapid respiration and rapid pulse are difficult to evaluate in the traumatized individual.

So often the chest film consists of a supine chest radiograph taken with a portable apparatus with all the associated problems of the portable film. But with an awareness of the increased frequency of pulmonary emboli, minimal findings on the chest film are important. Changes such as an elevated diaphragm leaf, discoid atelectasis, a prominent hilum, an oligemic lung (decreased vascularity), a plethoric lung (increased vascularity, and hemispherical consolidation along a pleural surface (Hampton's hump) are extremely significant.

Lung scanning is a simple and effective procedure and can be performed with a minimal discomfort and a high degree of safety. Moving a post-traumatic patient to the department is the biggest obstacle in performing the examination. The presently employed radiopharmaceutical is I-131, labeled macro-aggregated albumin, and the Anger scintillation camera is the best imaging device.

It is important to obtain the scan as early as possible after suspecting the process and prior to the appearance of opacity on the chest radiograph. A perfusion defect on the scan where there is no corresponding opacity on the chest x-ray is almost pathognomonic of an emboli, if lung cysts and bullae are excluded.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Hospital, Jackson, Miss.

This particular case involved a 28-year-old white male who was admitted to the Mississippi Baptist Hospital following a severe automobile injury. He sustained sternal and abdominal injuries. The abdominal injury was due to the seat belt in which a ruptured ileum was found. A sternal fracture was also demonstrated. While in the hospital he became hyperpneic and pale.

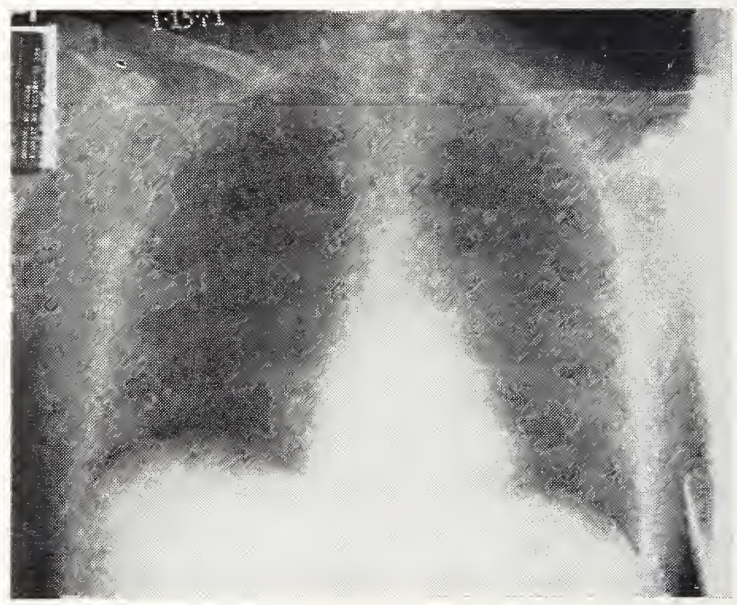


Figure 1. A few hours after onset of symptoms, a chest radiogram shows a decreased vascularity on the right and an increased vascularity on the left, indicating a shunting of pulmonary arterial flow from the right lung to the left.

Chest films showed an increased vascularity in the left lung in comparison to the right. There was no definite infiltration identified on the first film. Later, a repeat chest film did show this same increased vascularity on the left, but in addition, a small Hampton's hump consolidation was noted in the mid lung area.

The lung scan shows that there is a marked perfusion defect in the right lower lobe and also a

"shrunken" right upper lobe. In addition, a well-defined perfusion defect is seen in the base of the right upper lobe with convexity toward the hilum. On the left side the perfusion pattern is seen to be dense, indicating a shunting of the



Figure 2. Note the multiplicity of perfusion defects, the dense left lung and overall decrease in perfusion in right lung.

arterial blood to this side. Also, there are seen two defects, one in the extreme base along the diaphragm leaf and the other in the mid lung area, having the classical crescentic appearance of an infarct.

The patient did not respond to anticoagulant therapy and when he developed further shortness of breath and considerable chest pain in a different area, it was felt that he was continuing to throw more pulmonary emboli into a lung which was already seriously compromised. The inferior vena cava was ligated and the improvement was prompt. Undoubtedly, the prompt improvement was related to a decrease in the reflex vascular constriction with the cessation of the embolic shower. A lung scan three weeks later showed an essentially normal left lung and a marked improvement of the right lung.

Inferior vena caval ligation may be a life-saving procedure but is seldom necessary or indicated. Anticoagulant therapy, heparin, has been established as the usual treatment of choice.

The perfusion defects seen on the scan reflecting impairment of pulmonary arterial blood flow must be evaluated in conjunction with the clinical history and findings, laboratory data, and

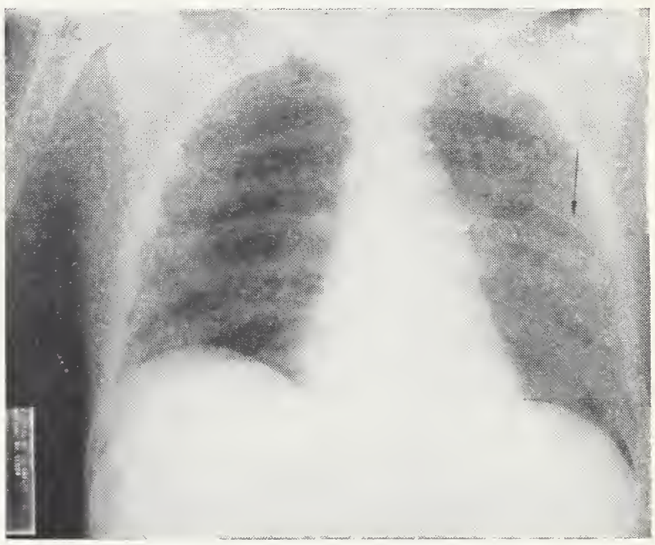


Figure 3. Three days later a classical hemispherical consolidation along a pleural surface (Hampton's hump) had developed.

chest radiographs. But with this correlation, it provides a very accurate study which aids greatly in establishing an effective treatment plan, usually long-term anticoagulant therapy. ★★★

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TAX TIP

The best reason for hiring a C.P.A. to do your income tax is the saving of time—perhaps as much as 20 years.



The President Speaking

'Calling Our Own Shots'

ARTHUR E. BROWN, M.D.
Columbus, Mississippi

THIRD PARTY PAYMENTS have become a way of life in medical care delivery. Yet, we are flooded with the written and spoken word about the high and mounting costs of medical care. For most patients and many physicians, incentives for containing care costs have been eroded away. The patient knows that he is "covered." The physician may accept the same viewpoint, and this is where overutilization of medical manpower and facilities begins.

At every hand, proposals are being devised to finance care at rising rates. Simultaneously, restraints are within the grasp of all without the compulsion and oppression of another layer of bureaucracy, and it is time that we focus attention on bringing medical care costs into line with quality.

To illustrate, let us hypothecate a care circumstance in a 150 bed hospital. There are many thousands of such institutions in the nation. Let us recognize—conservatively, at that—an overstay of one day by 50 patients. By this, we mean one day longer than is medically necessary. One such extra and unnecessary day at $40 per day totals out $2,000 per day. That is $730,000 per year for our hypothetical 150 bed hospital. Since the chances are that we will have more than this modest and conservative overstay, we are talking about $1 million per year for our facility which was needlessly expended. Now apply this to the thousands of hospitals throughout the United States, and we arrive at an astronomical total, certainly more than $1 billion.

What is encouraging is that medicine is doing something about this through medical care foundation peer review programs. The Certified Hospital Admission Program (CHAP) in California screens all elective admissions in advance, projecting a length of stay, in *perspective* rather than *retrospective* review.

Our state medical association is taking the beginning steps for orderly, physician-oriented, physician-managed peer review. We have organized our Mississippi Foundation for Medical Care. We have entered upon an important research project with our Experimental Medical Care Review Organization (EMCRO), financed for two years at $369,000. We are calling our own shots, and we intend to assure quality care at reasonable costs. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 10

OCTOBER 1971

EDITORIALS

President Nixon's Freeze and Health Care Economics

I

THE ECONOMIC PATIENT is six weeks postoperative from the trauma of President Nixon's radical wage-price freeze procedure. A healthy pressure of about 900 has been holding on the Dow Jones charts. The infection of inflation has subsided, and most seem to feel that the treatment regimen of choice has been initially successful.

Where the difficulty lies is in the long term prognosis. Or, better yet, what happens after Nov. 14 with the expiration of present inpatient treatment? A pertinent question, this, because the economics of health care, being a substantial 7 per cent of the United States' gross national product, figures prominently in the picture. The medical care cost equation has many tricky components, some not easily translated into simple monetary terms. Moreover, changing technology and science constantly alter economic necessities.

All of these questions are cropping up among the thousands of inquiries about the President's actions, and the effect upon medical practice is a first. For example, price freezes during World War II and the Korean Conflict specifically excluded physicians' fees. But, as AMA General Counsel Bernard D. Hirsch points out, government has become one of the largest purchasers of health care, and this makes a difference. So these questions are of importance to physicians, hospitals, allied health professionals, and to every member of the health care team.

II

No single series of economic actions in a generation are comparable to Executive Order 11615 of Aug. 15, 1971, just in case anybody ever wants to know the exact legal reference. President Hoover closed the banks and invoked a moratorium on credit and exchange. President Roosevelt took the nation off the gold standard, and President Truman went into the railroad business when he ordered a government takeover of the common carriers. In the economic slump of 1957, President Eisenhower used a light touch, mostly with infusion of federal funds.

President Nixon's sweeping actions derive from authorities in the Economic Stabilization Act of 1970 which is mainly an anti-inflation measure. The wage-price freeze provisions of the Act were among the portions which the administration actually opposed as unnecessary. The real debate in enactment of the measure centered around balance of payments, imports, and foreign exchange.

Ironically, the administration's anti-inflation program had been working admirably and effectively for nearly a year. Interest on money

was down, and the cost of living was 2 per cent under the meteoric rise of 1970. Despite these two prime indicators, wages were up, and personal disposable income was at an all-time high. Yet, savings by individuals were exceeding $25 billion annually, providing not only rainy day reserves but also diminishing runaway price increases by wildly increasing purchase of consumables.

The crisis, not exactly an unforeseen, dramatic and explosive incident, had built to critical proportion on the import and international exchange scene. The dollar, once the darling of the gnomes of Zurich who trade currencies like tomatoes at Crystal Springs, was weakening with an economic anemia of alarming proportion. The war in Southeast Asia and U. S. military forces at bases throughout the world constitute a $40 billion annual drain.

Automobiles, steel, electronics, optics, luxury items, and even cotton were pouring into the United States to compete with domestic products, draining away dollars while we dealt in foreign currencies overseas, bolstering their already high values. Something had to be done, and President Nixon took the first critical step.

III

But back in Hometown, Miss., there is a hospital to operate, physicians' offices to be maintained, wages of nurses, assistants, and other allied professionals to be paid, medical supplies to be purchased, and a host of other expenses to be met in serving the health needs of the community. In Capital City, U.S.A., there are medical care plans, health insurance companies, and voluntary prepayment programs with continuing responsibilities in health care financing.

All of these services, institutions, and professional persons must now deal in frozen wages, prices, fees, and premiums, each a necessary aspect of the health care services complex.

The Executive Order states that "prices, rents, wages, and salaries shall be stabilized for a period of 90 days from the date hereof (Aug. 15, 1971) at levels not greater than the highest of those pertaining to a substantial volume of actual transactions by each individual, business, firm or other entity of any kind during the 30-day period ending Aug. 14, 1971, for like or similar commodities or services. . . ."

So many questions pertaining to medical practice not spelled out in the legal gobbledegook arise:

May a physician increase his fee for a given service?

—As such, no. The freeze is absolute if the physician employs a standard or fixed fee schedule. It is also absolute for insurance, Blue plan, and government program maximum benefit schedules. But with prices stabilized "at levels not greater than the highest of those pertaining to a substantial volume of actual transactions" in the month before the freeze, the physician could charge for a procedure at the highest usual level when he employs a varying scale.

The Cost of Living Council, established by the Executive Order and which possesses the powers of the President himself, defines "substantial volume" price as the ceiling price at or above which 10 per cent of the actual transactions during the base period were made. So if a physician had charged $10 for a given service half the time and less than $10 on other occasions, he may still charge $10 with no penalty for the lesser charges. This is in distinct contrast to recent Medicare freezes at the lowest single profile charge.

A physician raised his secretary's salary effective Aug. 1, but her next payday was Aug. 31, whereas the freeze was invoked Aug. 15. May he still pay the greater amount?





"I think we can safely rule out malnutrition."

—Yes, if there are records to prove this is the case. But deferred salary increases are not permitted nor are cost-of-living increases, even though previously agreed to.

What about new jobs in a physician's office or a bona fide promotion of an employee?

—Since the salary of a job which did not exist on Aug. 15 cannot be frozen, the employer is obliged to fix it at the nearest comparable salary previously paid in the office or in similar office organizations. Increased pay to an employee for *bona fide* promotions involving greater responsibilities and work is allowed. Periodic merit increases are not permissible.

Are drug prices frozen at wholesale and retail levels?

—Yes. But a new drug product marketed during the freeze may be priced to the nearest competitive product and sold.

Does the price freeze apply to premiums for insurance, including professional liability, life, health and accident, and property?

—Yes, even if the carrier had intended to increase premiums.

Are interest rates charged on loans frozen?

—No, the Economic Stabilization Act does not apply to interest charges or to corporate profits, so the President had no authority to freeze these.

Are tax rates frozen?

—No, whether local, state, or federal. Even the new 10 per cent import tax surcharge may be passed along to the purchaser, but it may not be added to imported items in stocks of the seller on Aug. 15.

IV

The Executive Order, intended to cut a swath across the nation's economy, has and will continue to affect health care delivery economics. For domestic manufacturers of medical supplies, equipment, and drugs, it will permit a 10 per cent tax reinvestment credit when the plough-back in plants and facilities actually creates new and additional jobs. Conceivably, this could lower prices in the domestic market while increasing productivity.

Overseas, the dollar's hemoglobin is up, because the President's action closed the gold window for dollar redemption. With $30 billion in the hands of foreign governments, banks, and businesses and $14 million in gold at Ft. Knox, suspension of dollar convertibility was the only sane course, and it was something which conservative economists had advocated for years. Although the nation had been off the domestic gold standard (where you could get a dollar's worth of gold for a dollar bill) since 1935, no such restriction had been placed on foreigners. With the unfavorable balance of payments, the outflow of gold had been steady.

Foreign currencies, especially the Deutschemark of West Germany and the Japanese yen, tended to rise in value during recent years, as nations trading with the United States have prospered. The effect has been to exacerbate the trade imbalance. By closing the gold window and floating the dollar in the international market, truer parity is achieved, slowing down the velocity of foreign imports into the United States. All of this, fortunately, doesn't bother the dollar at home in domestic markets.

But where we go from here is a vital matter which the American health care delivery system must watch. Domestic aspects are primary, involving health care financing of nearly $80 billion in the trillion dollar-plus GNP. In practice, the freeze and other economic dicta will work on a short term basis and in theory, on an interim basis. But growing demand, supply of services, and changing technology must bring changes economically which temporary measures, however drastic, cannot arrest.

Ultimately, the free market is the only answer for the nation which continues to deliver the most and best medical care in the world.—R.B.K.

Unproved Optimism and Theories on HMOs

Why all the noise about HMOs? Their alleged virtues? Their being some sort of easily attainable ultimate in health care delivery? And the enchantment which they lend to easing pressures upon the voluntary health care delivery system?

With the flood of literature, papers, bulletins, pamphlets, reports, and studies abounding on HMOs, it is doubtful if one out of 100 even knows that the letters stand for "health maintenance organization." Even fewer understand that proponents of HMOs are merely urging extension of prepaid group practice or closed panel plans.

There are strong feelings on all sides of the HMO debate, but when the cobwebs of emotion have been swept away, some facts remain which merit serious consideration.

So that no charge of bias against the JOURNAL may be made in a policy position, let it be understood that the Mississippi State Medical Association *has never* and *does not now* endorse the HMO concept. As with other state medical associations, Mississippi has full appreciation for a pluralistic delivery system, another way of supporting full, free choice. The association does endorse private care delivery and voluntary health care financing.

Proponents of HMOs appear to feel that this concept will alleviate the imbalance between the demand for physicians' services and the supply of services available. They feel that the HMO concept will decrease the cost of medical care, that barriers to care accessibility will be brought down, and that organizational inefficiencies (which the proponents charge as existing) will be rectified.

But the validity of these generalized contentions rests upon something yet unproved, the characteristics of desirability attributed to closed panel groups. Interestingly enough, HEW financed a study on HMOs which raises the same question. So this is a little like extolling the excellence of a recipe which has yet to be cooked, served, and tasted.

One unproved assumption is that large groups of physicians are more efficient than smaller practice groups. At what point is this so, if, indeed, it is at all? Nobody knows. And it is also contended that "incentives" exist in HMOs which cannot exist in small or solo practice units. If so, how how good are they, and how effective will they be at some stated point of practice unit size?

Prepaid groups have a lower rate of hospitalization utilization for patients, but is this really *less use* of hospital facilities or a *shorter stay?* In like context, is the reduction in hospital costs attributed to closed panel groups only a reduction in expenditures? There is a difference between *price* and *cost*.

Proponents of prepaid groups—and hence, HMOs—contend that preventive care is the answer. Is this myth or reality? Have we, as a matter of fact, never practiced preventive medicine? Of course, with the greatest saving of life and prevention of disease. How much malaria or typhoid fever are around today? If anything, preventive medicine has been so successful as to create a backwash of longer life, new degrees of chronicity, and exaggeration of geriatric problems. Fifty years ago, there was little to worry about in the over-65 group, what with most dying in the fourth and fifth decades of life from infectious disease.

Then, as a parting shot, how can the HMO "guarantee access" any better than any other concept? In fact, is it really a guarantee or a hunting license? A broad commitment to the HMO concept for public care programs would be a grave mistake, because there is no assurance that more and better care would thereby be delivered for less money. AMA has expressed doubts; thoughtful members of the Congress have expressed doubts; and we express doubts that compulsory change of unproved nature could deliver the promises of its proponents.

It is well understood that the HMO concept is embodied in many pending programs, none of which has as yet become law. Money is available for experiment in HMOs. Kaiser-Permanente and other prepaid groups have years of experience, but less than 3 per cent of all Americans avail themselves of this facet of the delivery system. Let these facts be considered and weighed seriously, and let the Congress make no hasty and unwise decisions.—R.B.K.

Botulism, Sensationalism, and Mrs. Murphy's Chowder

In the Gay 90's, everybody wanted to know who threw the overalls in Mrs. Murphy's chowder. Now, they're asking which one of the six strains of botulism might be in the soup.



"I thought I told you to wait for me in Rome!"

The Bon Vivant affair of the botulism-infected vichyssoise put a century-old food processor into bankruptcy and made suspect one of the most carefully regulated industries in the world. Then a series of incidents ensued: More suspected soup contamination, cheese with pesticide residue, jelly with glass particles, and a host of fearful happenings.

What is important is to understand the rigorous standards of sanitation and quality controls which the food processing industry imposes upon itself. Top that off with the tough FDA standards, and then add the meaning of a good brand name in a free, competitive market. It all adds up to the fact that we Americans eat the safest, highest quality food in the world.

No physician need be reminded of the dread which is inspired by botulism, but its rarity has been overshadowed by the power of mass media. About 40 cases are diagnosed annually in the United States, and virtually every one comes from home-processed food, usually homecanned foods. About 30 per cent of the victims die, because of delayed diagnosis fostered by sometimes insuperable difficulties. Once diagnosed, the condition can be best treated, the experts say, in an intensive care unit.

But the fact of the matter is that conditions of this rarity are clinical problems of near zero significance statistically, although of great concern medically to physicians. No reliable data are available on the magnitude of botulism deaths labeled "ptomaine poisoning" a couple of generations ago.

The self-policing of the food processing industry gives great assurances, along with the rarity of the condition. Perhaps the best thing would be for us home-canners to think twice before open boiling or insufficient container cleansing and sterilization. And the FDA isn't asleep, either. The mass news media would do well to put these types of sensational stories into proper perspective.—R.B.K.

"C" Is for Cultism and "O" Is for Ouch!

The cult of chiropractic is getting stung where it hurts, and cries of anguish are beginning to come from the spine punchers. First, there has been the unrelenting campaign of the American Medical Association which was begun in the mid-1960's, a welcome and refreshing change from years of inaction.

So effective has this campaign become that its spinoff is stronger than the AMA effort. Not a single agency of the federal government favors the cult:

—HEW has denounced chiropractic and urged that it never be included in Medicare.

—No medical agency of the federal government, including the U. S. Public Health Service, Veterans Administration, or armed forces, recognizes the cult of chiropractic.

—The Congress, although pressured by chiropractic lobbies, has steadfastly declined to include it in any health care plan.

All of this has elicited moans from chiropractic spokesmen, most recently from one Robert L. Thatcher of St. Paul, said to be national legislative chairman for the American Chiropractic Association.

Chiropractor Thatcher complained, according to recent Associated Press stories, that the "AMA is irresponsible to the health needs of the public" by opposing chiropractic. The statement comes as no surprise, because as a legislative chairman, chiropractor Thatcher is notably unsuccessful.

"The problem does not lie with the competent, local medical doctor but rather with the politically oriented AMA," Thatcher was quoted as saying. "The AMA is attempting to bias the average local medical doctor against the chiropractic profession," he added.

Exactly so, except for one thing: The local physician *is* the AMA which does his bidding through a representative process, carrying out the will of the majority as determined by elected delegates from every corner of the United States.

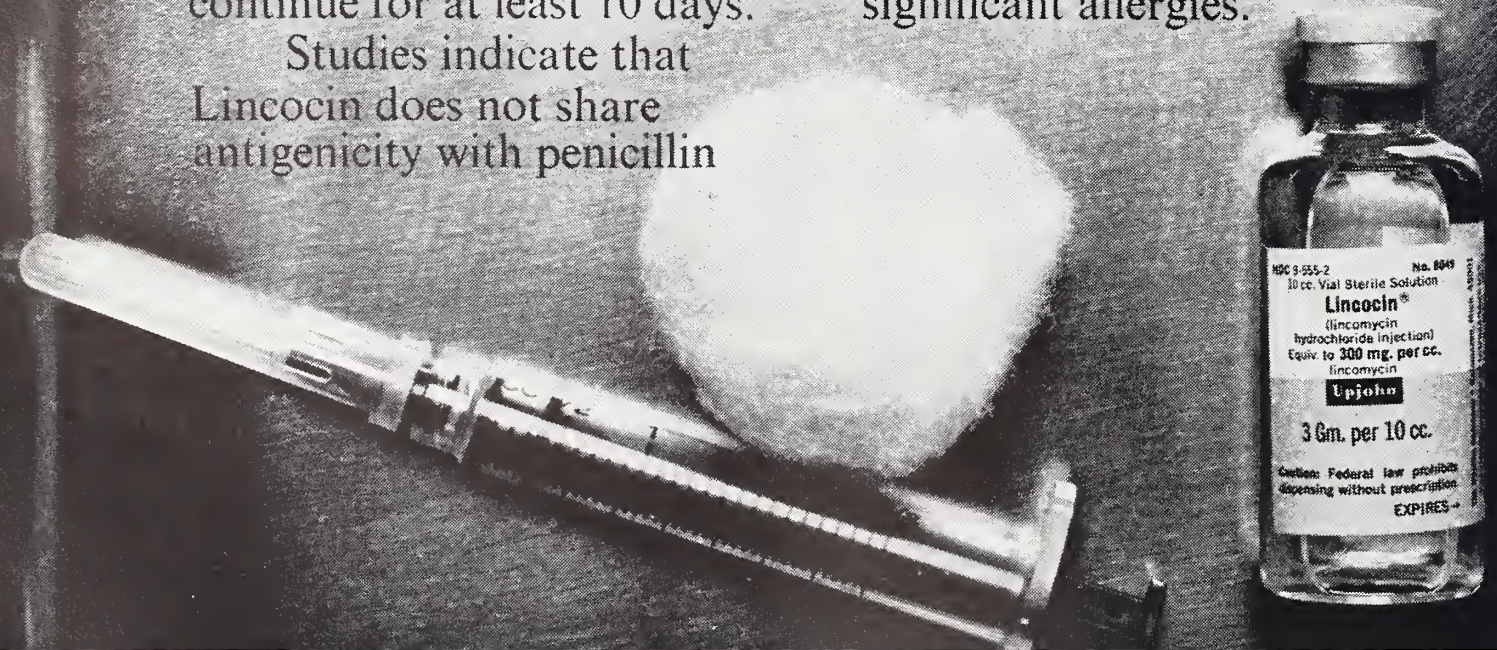
But successes against this cult on the national scene are no reason for two Southern states, Louisiana and Mississippi, to relax their vigilance and continuing fights. They alone have no chiropractic licensure with the sanction of state law and badge of statutory respectability for this cult. It is a way of saying that protection of the public health is a job which never ends.

The AMA is to be commended for its continuing campaign and its positive response to the individual medical practitioner who, better than anyone else, understands the danger and tragedy of quackery.—R.B.K.

Hypersensitivity to penicillin is a good reason to consider Lincocin®
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Lincocin (lincomycin hydrochloride, Upjohn) has produced a high percentage of satisfactory responses in patients with mild, moderate and severe infections due to susceptible streptococci, pneumococci and staphylococci (including many penicillinase-producing strains). With β-hemolytic streptococcal infections, treatment should continue for at least 10 days.

Studies indicate that Lincocin does not share antigenicity with penicillin compounds. However, hypersensitivity reactions such as angioneurotic edema, serum sickness and anaphylaxis have been reported, some of these in patients known to be sensitive to penicillin. As with any antibiotic, Lincocin (lincomycin hydrochloride, Upjohn) should be used cautiously in patients with histories of asthma or other significant allergies.



Book Reviews

Obstetrics and Gynecology. Fourth Edition. By J. Robert Willson, M.D., Clayton T. Beecham, M.D., and Elsie Reid Carrington, M.D. 638 pages with 525 illustrations. St. Louis: The C. V. Mosby Company, 1971. $19.80.

The first sentence in the preface to the fourth edition of this book is in essence a good summary of the purpose for which this book was created. "In preparing the fourth edition of Obstetrics and Gynecology we have attempted to maintain the concept that the book serves best as a text for medical students and as a reference on the basic principles of reproduction for physicians in all fields."

As a practicing physician, it was quite refreshing to review a textbook. The didactic approach by the authors with outline form and easy to follow discussion holds one's interest.

It is our thought that the authors have done an excellent job in coordinating the older more established basic obstetrical and gynecological knowledge with that of the newer psychological and scientific aspect of the patient.

RICHARD S. HOLLIS, M.D.

Handbook of Psychiatry. Edited by Philip Solomon and Vernon D. Patch, M.D. 648 pages. Los Altos: Lange Medical Publications, 1971. $7.50.

The Lange Medical Publication Company with the help of Dr. Solomon has presented us with an exceptional handbook in the field of psychiatry. The quality of the book itself is commensurate or superior to the Lange handbooks of the past. The book is a well written, well organized summary of the field of psychiatry and related fields. The actual printing itself, while in rather small type, is organized and printed so as to make enjoyable reading.

This book certainly is no textbook, but is just as the name implies, a handbook and reference summary. To a general medical reader I am sure that this book would be helpful in informing him of what is happening in psychiatry with the minimal of reading. The book also includes a complete psychiatric classification and a two page summary that will enable one to handle most any acute psychiatric emergency.

Each chapter of the book is written by an expert in the field, oftentimes ably assisted by Dr. Solomon. While each chapter is excellent, I will single out a few that were particularly interesting to me. The chapter on drug dependence is 15 pages long, makes adequate mention of most misused drugs and in the page and a half of references completely covers the field.

The following chapter on suicide is written by Dr. McCourt and Dr. Solomon. This chapter is eight pages long and probably contains more pertinent helpful data than most books of five or six hundred pages. In the chapter, suicide is discussed from an overall general point of view, then the psychological causes of suicide are mentioned. Then suicide is looked at from the sociological theories of the causes. The next point in the chapter is assessment of suicidal risks and suicidal attempt. This is a most helpful section and will interest most practitioners. Prevention of suicide is then discussed and specific, helpful, practical tips are given. Brief mention is made of treatment and of prognosis.

The section on child psychiatry was especially good and I think an attempt is made to cover the field pretty well. Of particular interest and help was the miscellaneous psychiatric disorders of childhood section. In this section specific symptoms were mentioned. One of these was school refusal or school phobia. No specific mention of treatment is made, but an adequate discussion is present to enable one to make the diagnosis. Another symptom mentioned is fire-setting and reading disabilities.

In the section under special problems of infancy and preschool years, the feeding, sleeping, and speech difficulties are mentioned and covered fairly adequately. Rocking and head banging is mentioned, also problems related to toilet training, and problems related to excessive anxiety. As in the previous section, little mention is made of specific treatment; however, at the end of the chapter treatment methods and possibilities are adequately outlined.

I would certainly recommend this book to any physician who deals with people who have psychiatric problems. While this is not intended to be a text it does seem to fulfill the intent of supplying rather quickly an overall view of the current picture of psychiatry and related areas.

JERRY M. ROSS, M.D.

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Precautions: Should be used with caution in patients who have glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.
Adverse Reactions: Side effects reported to date have been predominantly related to rash (which requires discontinuation of medication) and headache and gastrointestinal distress, which are usually mild and transient with continuation of medication. In some cases severe persistent headaches may occur. In addition, the following adverse reactions to nitrates such as pentaerythritol tetranitrate have been reported in the literature: (a) Cutaneous vasodilatation with flushing. (b) Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. (c) An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur, ever with the usual therapeutic doses. Alcohol may enhance this effect.
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Additional Dosage Forms: PERITRATE (pentaerythritol tetranitrate) 10 mg and 20 mg tablets with or without phenobarbital 15 mg, bottles of 100 and 1000 tablets. PERITRATE with Phenobarbital SA Sustained Action—pentaerythritol tetranitrate 80 mg and phenobarbital 45 mg, bottles of 100 and 1000 tablets.
Warning: Tablets containing phenobarbital may be habit forming. PERITRATE with Nitroglycerin—pentaerythritol tetranitrate 10 mg with nitroglycerin 0.3 mg, bottles of 50 tablets.

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POSTGRADUATE CALENDAR

UNIVERSITY MEDICAL CENTER POSTGRADUATE EDUCATION

Oct. 4-8, 1971

ELECTROCARDIOGRAPHY INTENSIVE COURSE
University Medical Center, Jackson
Oct. 4-8, 1971, beginning at 8 a.m.

Sponsored by The University of Mississippi School of Medicine, with the support of the Mississippi Regional Medical Program

Coordinator:
Thomas M. Blake, M.D., professor of medicine, The University of Mississippi School of Medicine

This one-week intensive course, the first of the 1971-1972 session, will consist of a series of discussions on selected topics in electrocardiography on the basis of their immediate clinical applicability. Participants will work with electrocardiograms, slides and other visual aids and will have the opportunity to interpret electrocardiograms.

Oct. 18-22, 1971

PEDIATRICS INTENSIVE COURSE
University Medical Center, Jackson
Oct. 18-22, 1971, beginning at 8 a.m.

Sponsored by The University of Mississippi School of Medicine, with the support of the Mississippi Regional Medical Program

Coordinators:
J. M. Montalvo, M.D., associate professor of pediatrics, The University of Mississippi School of Medicine
Nell J. Ryan, M.D., associate professor of pediatrics, The University of Mississippi School of Medicine

Registrants for this one-week intensive course will participate in ward and intake rounds, and refresh their skills in such areas as scalp vein techniques, use of the respirator, resuscitator, nebulizer and humidifier. They will attend lectures on fluids, hematology, cardiology, immunizations, allergies, seizures, pediatric emergencies, pediatric surgery, renal problems and care of the newborn.

Both intensive courses, along with six other courses to be offered twice this year, are part

POSTGRADUATE / Continued

of the Mississippi Postgraduate Institute in the Medical Sciences, a Mississippi Regional Medical Program-funded project. Designed for family physicians, each class is limited to five registrants from those enrolled in the Institute.

FUTURE CALENDAR

October 4-8, 1971
ELECTROCARDIOGRAPHY INTENSIVE COURSE

October 18-22
PEDIATRICS INTENSIVE COURSE

October 21
CIRCUIT COURSE, CLARKSDALE

October 28-29
SEMINAR ON HIGH RISK PREGNANCY AND PROBLEMS OF THE NEWBORN

November 1-5
RADIOLOGY INTENSIVE COURSE

November 4
CIRCUIT COURSE, CLARKSDALE

November 8-12
NEPHROLOGY INTENSIVE COURSE

November 15-19
GASTROENTEROLOGY INTENSIVE COURSE

November 16
PULMONARY DISEASE SEMINAR

November 18
CIRCUIT COURSE, CLARKSDALE

November 29-December 3
OBSTETRICS INTENSIVE COURSE

December 6-10
STROKE AND NEUROLOGICAL DISEASE INTENSIVE COURSE

January 10-14, 1972
ELECTROCARDIOGRAPHY INTENSIVE COURSE

February 7-11
GASTROENTEROLOGY INTENSIVE COURSE

March 13-17
OBSTETRICS INTENSIVE COURSE
STROKE AND NEUROLOGICAL DISEASE INTENSIVE COURSE

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March 20-24
CARDIOLOGY INTENSIVE COURSE

April 10-14
PEDIATRICS INTENSIVE COURSE

April 17-21
CARDIOLOGY INTENSIVE COURSE

April 24-28
RADIOLOGY INTENSIVE COURSE

May 1-5
NEPHROLOGY INTENSIVE COURSE

May 8-11
MISSISSIPPI STATE MEDICAL ASSOCIATION. BILOXI

DEATHS

MAGILL, HUGH B., JR., Biloxi. M.D., Emory University School of Medicine, Atlanta, Ga., 1935. Interned with the United States Public Health Service; died Aug. 18, 1971, age 63.

NEW MEMBERS

BENOIST, LOUIS ARMAND, III, Natchez. Born Natchez, Miss., Sept. 6, 1944; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1970; interned Confederate Memorial Medical Center, Shreveport, La., one year; elected Aug. 1971 by Adams County Medical Society.

ELLISON, RICHARD BEIRNE, Biloxi. Born Charlotte, N. C., Oct. 23, 1934; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1959; interned Tripler General Hospital, Honolulu, Hawaii, one year; radiology residency Letterman General Hospital, San Francisco, Calif., Aug. 1962 to Sept. 1965; elected March 1971 by Coast Counties Medical Society.

WESSON, RAY LAMAR, Biloxi. Born Meridian, Miss., May 22, 1937; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1963; interned same for one year; general surgery residency, same, July 1964 to June 1968; elected March 1971 by Coast Counties Medical Society.

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Gulf Coast Athletic Injury Seminar Held

The Athletic Injury Seminar for Gulf Coast football coaches and team physicians was held Aug. 5 at Howard Memorial Hospital in Biloxi.

The annual event, held under the auspices of the Trauma Committee of the American College of Surgeons, was sponsored by Howard Memorial medical staff, Bel-Bru Sporting Goods of Biloxi, and Sportman's Corner, Inc. of Gulfport.

Drs. Archibald C. Hewes of Gulfport and Ray L. Wesson of Biloxi were moderators for the program which included presentations on heat exhaustion, head and neck injuries, pre-training medical evaluation, demonstration of new equipment, and injuries of upper extremity, knee and ankle and skin and soft tissue.

Other physicians participating were Drs. D. L. Hollis of Biloxi, Joseph Kuljis of Notre Dame, Glen Warren of Keesler Air Force Base, John B. O'Keefe of Biloxi, and Daniel J. Enger of Pascagoula. Also on the program were Larry "Doc" Harrington, University of Southern Mississippi trainer, and Mr. Erin Smith of Jackson, Central School Supply.

PERSONALS

BERNARD H. BOOTH has associated with the Mississippi Allergy Clinic, P.A. for the practice of allergic and immunological diseases at 940 N. State Street in Jackson.

G. A. BYNUM of Hattiesburg is serving as president of the board of Beeson Academy.

CURTIS W. CAINE of Jackson has been named "Man of the Year" by the state Women for Constitutional Government. Dr. Caine will be honored at the state convention of W.C.G. in McComb.

RICHARD H. CLARK, JR., of Hattiesburg has been elected president of the newly established air ambulance district representing Forrest, Lamar, Marion, Covington and Jefferson Davis counties. Also on the board of directors is C. P. CRENSHAW of Collins.

H. M. FAIRCHILD has associated with LAMAR THAGGARD of Madden in the general practice of medicine in that community.

W. L. JACQUITH of Whitfield took part in a panel discussion on legal and professional aspects of drug dispensing and administration at a drug control seminar sponsored by the Mississippi Board of Nursing in Jackson.

W. B. LARKIN, JR., has associated with E. J. SCHMIDT of Bude for general practice at the Bude Clinic.

M. F. LONGNECKER, JR., has opened his office at 1210 West Division in Biloxi for the practice of orthopedic surgery.

W. J. MANUEL has opened his office in the Bel Air Shopping Center at Pascagoula for the practice of dermatology.

WILLIAM C. MCQUINN of Jackson has been been elected a national director of Contact Teleministry, Inc. and was installed at the recent convention in Cincinnati.

DAVID L. MEADOWS has joined MILLARD S. COSTILOW in North Carrollton for the general practice of medicine.

BENJAMIN P. MONACO announces the opening of his office for the practice of ophthalmology at 1930 Old Mobile Highway in Pascagoula.

JOSEPH M. MOORE of Vicksburg was honored by Vicksburg Hospital associates recently upon his retirement after 25 years of service in Vicksburg.

LEO J. SCANLON, JR., has associated with the Vicksburg Clinic in the department of anatomical and clinical pathology.

N. E. MURILLO SMITH announces the opening of offices for the practice of general medicine at 1411 22nd Avenue in Meridian.

GUY T. VISE, JR., formerly of Meridian, has joined the Central Orthopaedic Clinic P.A., 421 South Stadium Circle in Jackson, for the practice of orthopaedic surgery.

BILLY N. WATKINS has associated with EDWARD L. CARRUTH and JOHN E. MANN of Jackson for the family practice of medicine at 5429 Robinson Road.

RAY L. WESSON and JAMES WADDELL of Ocean Springs are serving as team physicians for the Greyhound football team.

Motorola Introduces Mobile EVR

Motorola Systems Inc. has unveiled "Mobile EVR," a simple, high-capability Cassette TV system for the nation's hospitals.

"Mobile EVR" allows hospitals to originate programs from EVR (Electronic Video Recording) cassettes, or to use the EVR system to transmit special interest material, using a closed-circuit camera.

John J. Harris, general marketing manager of Motorola Systems Inc., said the highly versatile "Mobile EVR" can be used for staff training and individual training, as well as for in-hospital information and entertainment.

"The unique package—the only such available to the hospital market—sells for under $2,000, not including camera," he said.

The many cassettes available from MOTOROLA TELEPROGRAM CENTER in the "Mobile EVR" package at the present time include staff education, patient education, child entertainment, and travel and adventures.

EVR, praised as one of the most important technological developments since television itself, is being marketed in the fields of medical care, business and industry, law enforcement, and education—both for its unique education and training value, as well as for entertainment.

Care Foundation Is Organized, Headed By Drs. Davis, Crawford and Gilmore

The Mississippi Foundation for Medical Care, Inc., became a legal entity under state law with issuance of a corporate charter and a going concern with organization at the summer meeting of the Board of Trustees.

Named to head the wholly-owned, nonprofit corporation of the state medical association was Dr. J. T. Davis of Corinth who is chairman of the Board of Directors.

Dr. Everett Crawford of Tylertown is vice chairman of the foundation's board.

Serving as secretary-treasurer is Dr. James O. Gilmore of Oxford, also a director of the foundation.

Officer-executives of the foundation named by the Board of Directors are Rowland B. Kennedy, president and chief executive officer, and H. Cody Harrell, vice president and comptroller.

Other directors on the 10-member board are Drs. Lyne S. Gamble of Greenville, Paul B. Brumby of Lexington, Carl G. Evers of Jackson, and Guy T. Vise of Meridian.

Also, Drs. W. E. Moak of Richton, James T. Thompson of Moss Point, and Millard S. Costilow of North Carrollton. Dr. Costilow is chairman of the association's Committee on Peer Review, described by the Board of Trustees as "the busiest committee in MSMA."

Legal work for the corporate organization was performed by Hon. Carl C. Bostic of Jackson who has served as legal counsel to the state medical association for more than 20 years. Incorporators were Drs. Davis, Crawford, and Gilmore who make up the Executive Committee of the Board of Trustees.

The corporate charter reflects sponsorship of the foundation by the Mississippi State Medical Association as authorized by the House of Delegates at the 103rd Annual Session last May. Purposes set out in the charter enable the foundation to administer medical care plans, contract for care delivery, perform peer review, conduct educational programs, and hold and own property.

The charter was approved by Mississippi Attorney General A. F. Summer, signed by Gov. John Bell Williams, and issued by Secretary of State Heber Ladner. The effective corporate date is July 6, 1971.

Membership in the Mississippi Foundation for Medical Care, Inc., is voluntary, and no dues have been assessed for 1971. Application forms will be made available to state medical association members during the fall, the directors said.

Initial work of the foundation will be educational, according to Dr. Davis. He said that "a series of informational programs, illustrated by color slides, will be presented before each component medical society and many hospital staffs and local groups."

For the present, the Experimental Medical Care Review Organization (EMCRO) continues under the state medical association, supervised by the Committee on Peer Review. The project is financed by a grant of $369,000 by the National Center for Health Services Research and Development through May 31, 1973.

Actions by the House of Delegates require that the Peer Review and EMCRO projects be brought under the foundation when it becomes fully operational.

The foundation will also have legal power and necessary staff to administer the CHAMPUS program which now serves about 80,000 beneficiaries in the state.

At the corporate organization meeting, the directors approved by-laws calling for no fewer than nine nor more than 12 board members. They are elected by the Administrative Members of the corporation for terms of three years

each on a staggered basis and may serve a maximum of nine years.

Administrative Members of the foundation are the nine Trustees of the state medical association, under actions of the House of Delegates. This assures control of the foundation by the association.

Participating Members of the foundation are those physicians who voluntarily choose to apply and avail themselves of foundation benefits in quality medical care plans and programs. A Participating Member must be a member of MSMA or a licensed practitioner in Mississippi fully eligible for membership.

Initial terms of directors provide three years each for Drs. Gamble, Gilmore, and Davis. Named for two year terms were Drs. Brumby, Costilow, Evers, and Vise.

Drs. Moak, Crawford, and Thompson drew one year terms to 1972. The arrangement will provide for election of a third of the board annually. For the present, the Administrative Members filled only 10 of the 12 authorized directorships.

The president and vice president, Messrs. Kennedy and Harrell, were named to one year terms and report to the board. Neither is a director nor will exercise voting privileges on the board.

Drs. Davis, Crawford, and Gilmore constitute the executive committee of the foundation's board.

"The chief purpose of the interlocking directors with MSMA," Drs. Davis, Crawford, and Gilmore said, "is to guarantee control of the foundation by the medical association, to assure implementation of policies approved by the association, and to achieve the fullest possible economies in operation of the foundation."

The foundation leaders said that "the foundation will always be responsive to the medical association and is, indeed, its creature."

"We have acted as the Board of Trustees to make certain that the foundation never goes beyond the reach of the state medical association, even if some association members choose not to participate," they added.

The leaders said that the Foundation's annual membership meeting will be conducted at the annual session of the state medical association, probably in conjunction with the House of Delegates. The membership meeting of the corporation will receive and act on reports and programs. It is also empowered to amend the bylaws.

Headquarters for the Mississippi Foundation for Medical Care, Inc., is at the association's building, 735 Riverside Drive, Jackson. No special space allocations are being made for MFMC activities, however, and the staff serves in dual capacities.

IRS Will Handle Price Freeze Questions

The Internal Revenue Service has established six "Service and Compliance Centers" in Mississippi to answer questions and receive complaints on violations of the price, rent, and wage freeze.

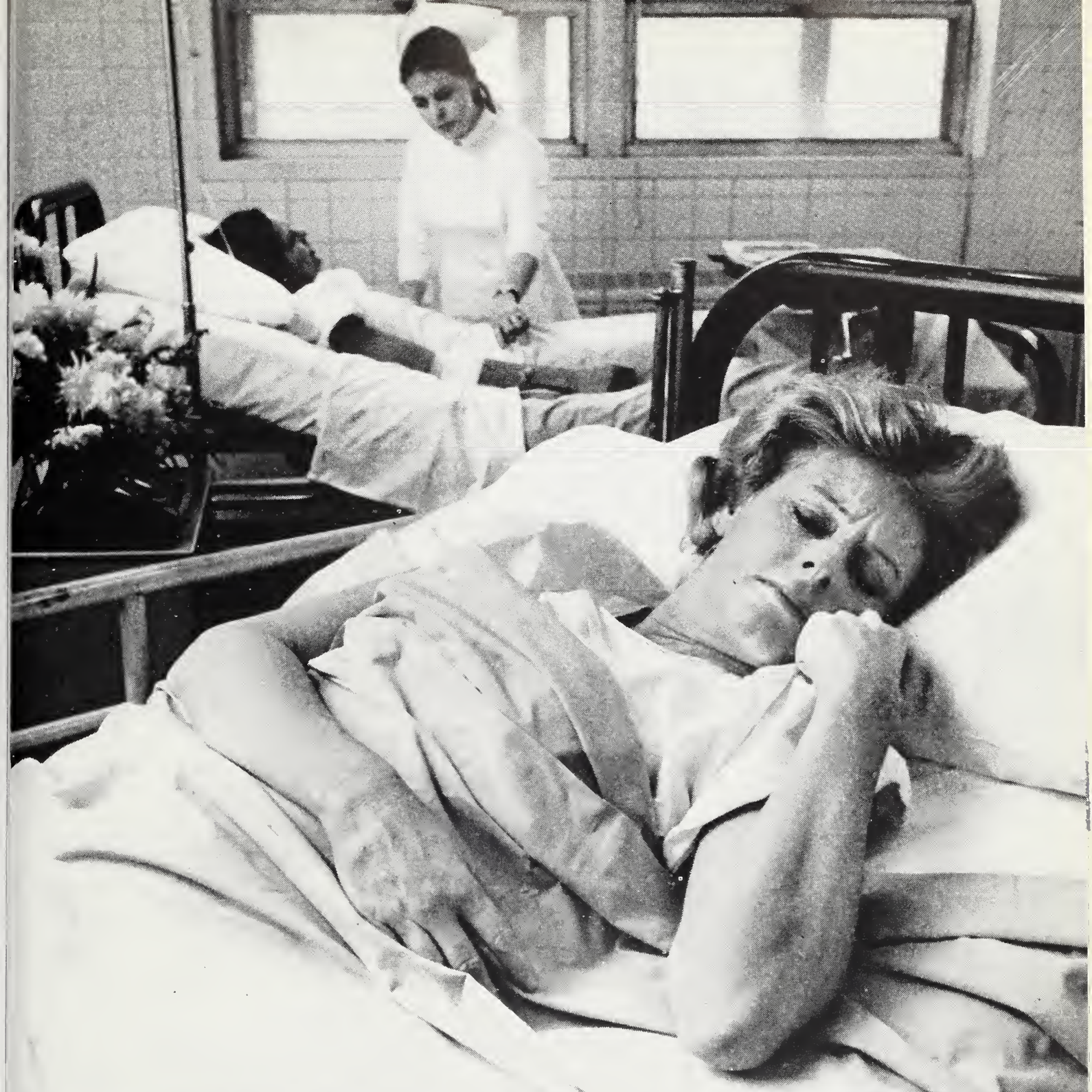
J. G. Martin, Jr., district director of Internal Revenue for the state of Mississippi, said that some of the local Service and Compliance Centers in the state were operational in late Aug.

So far, the Internal Revenue Service in Mississippi has not received an unusually large number of calls. To date calls have been in the nature of inquiries. IRS offices normally handle 250 calls a day on tax matters and are now receiving in addition about 40 calls a day involving price, rent, and wage controls.

The IRS offices are assisting the Office of Emergency Preparedness (OEP) in answering questions from the public. Internal Revenue Service has also been designated to receive and investigate complaints where necessary in regard to the freeze. In connection with complaints, once the facts are gathered by IRS personnel, it will be the practice of the service to exercise judgment in an attempt to resolve the differences, bringing about compliance. It will also be the practice of the service to protect the confidentiality of the information. Matters that cannot be resolved, where a violation has been determined, will be turned over to OEP.

Martin said the new role for IRS is not expected to produce an unmanageable workload or difficult problems for personnel. From the standpoint of service, the procedure being utilized and the nature of the work is very similar to that now being performed by the taxpayer service representatives in regard to tax matters. He also observed the compliance work that may need to be done is similar to the current investigative work in connection with tax cases.

IRS offices in Mississippi are open from 8:00 a.m. to 4:45 p.m. Monday through Friday to answer questions and process complaints. These offices are at Greenville, Gulfport, Hattiesburg, Jackson, Meridian, and Tupelo.



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Medical School Faculty Numbers 195

Faculty additions at The University of Mississippi School of Medicine since Jan., 1971, have brought the medical school faculty to a total of 195, including full-time, part-time and associate members.

Drs. Akio Suzuki, George V. Smith, and Edward Blanchard have joined the teaching staff as associate professors. Dr. Suzuki, a surgeon, received the M.D. degree at Tokyo Medical and Dental University. He interned at Tokyo U. S. Army Hospital and Albany Hospital in New York. As a resident, he trained at St. Vincent Charity Hospital in Ohio and the University Medical Center in Jackson. Dr. Suzuki was director of the Cardiovascular Surgery and Cardiac Research Laboratory at St. Vincent before his Mississippi appointment.

Dr. Smith, associate professor of surgery, earned the M.D. degree from Harvard Medical College. He interned at Charity Hospital in New Orleans and did his residency at Hartford Hospital in Connecticut. He came to Mississippi from the University of Connecticut where he was surgery assistant professor.

Associate professor of psychiatry (psychology), Dr. Blanchard holds the M.D. degree from Stanford University. Prior to his appointment, he was assistant professor of clinical psychology at the University of Georgia.

Five were added in at the assistant professor level. Dr. Patricia Norman is assistant professor of anesthesiology and instructor in obstetrics and gynecology (part-time). A Medical College of Alabama graduate, she did her internship and residency at University Hospital in Birmingham. She has held appointments at Harvard College and the Medical College of Alabama.

Dr. Gene G. Abel, psychiatry assistant professor, received the M.D. degree from the University of Iowa. He interned at the University of Florida Hospital and served his residency at the State Psychopathic Hospital in Iowa.

Assistant professors Dr. Robert L. Garrett, pharmacology, Dr. Dennis O'Callaghan, microbiology, and Dr. John McNair, anatomy, all earned the Ph.D. degree at the University Medical Center in Jackson. Dr. Garrett was previously Louisiana State University assistant professor of pharmacology. Dr. O'Callaghan was biochemistry assistant professor at the University of Alberta in

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Canada and Dr. McNair was on the Emory University faculty as anatomy instructor.

New medical school instructors are Dr. Gary P. Wood, obstetrics and gynecology, and Miss Betty Dean Pifer, biochemistry.

Dr. Myron W. Lockey, surgery assistant professor, has moved from the clinical to the full-time faculty. Additionally, Dr. James G. Dees, formerly clinical instructor in surgery, has been named an associate in surgery.

Faculty promotions announced with the new appointments include, at the professor level, Dr. Hermann Bader, previously associate professor of pharmacology.

Former assistant professors who have reached the rank of associate professor are Dr. John Bower, medicine; Dr. Arthur Hume, pharmacology; Dr. Gabriel L. Navar, physiology-biophysics; Dr. Robert L. Watson, preventive medicine, and Dr. Yoshio Kondo, surgery (research).

Promotions from instructor to assistant professor include Dr. Ancel Tipton, medicine (neurology); Dr. C. J. Kees, radiology; Dr. Hiroyuki Takagi, surgery; Dr. Krishnaro Potnis, obstetrics and gynecology; Dr. Harvey N. Chapin, psychiatry, and Dr. Robert McCaa, physiology-biophysics.

Dr. Mitchell Chairs Planning Council

Dr. J. Dan Mitchell of Jackson has been elected chairman of the board of directors of the Central Mississippi Health Planning Council. Richard H. Malone, president of Hinds General Hospital, was named vice chairman.

Other directors elected at the annual meeting are Mrs. Lura C. Ethridge, Dr. C. G. Sutherland, Foster L. Fowler, and Fred G. Corley.

These members will represent for the next year the interest of both providers and consumers of health services in metropolitan Jackson and the immediate surrounding area.

The board of directors contains 25 members, providing broad representation of the population of all seven counties served by the Central Mississippi Council.

Chartered in December, 1970, the Council was organized to fulfill the need for coordinated areawide comprehensive health planning in central Mississippi.

By applying under provisions of PL 89-749, the Council seeks designation as the official health planning agency to serve planning region VII, including Copiah, Hinds, Madison, Rankin, Simpson, Warren, and Yazoo counties.

Once approved by the state and federal planning agencies, the Central Mississippi Council will function as a clearinghouse for local applications for health related funding grants.

"The objectives of areawide health planning



Reviewing their certificate of election as officers of the Central Mississippi Health Planning Council are Dr. J. Dan Mitchell, left, chairman, and Richard H. Malone, vice chairman, both from Jackson.

are many and varied; however, the Central Mississippi Council will focus its attention on the needs of the people in our area, and on the circumstances which affect their physical, mental, and environmental health. The scope of comprehensive health planning includes all health needs or problems of all the population, and all means—services, manpower, facilities—to meet these needs or solve these problems," said Dr. Mitchell.

A majority of Council members must be consumers of health services. Consumer membership includes representatives of local governments, chambers of commerce, organized labor, industry, news media, law enforcement, environmental services, minorities, the poor, education, and other consumer groups and organizations.

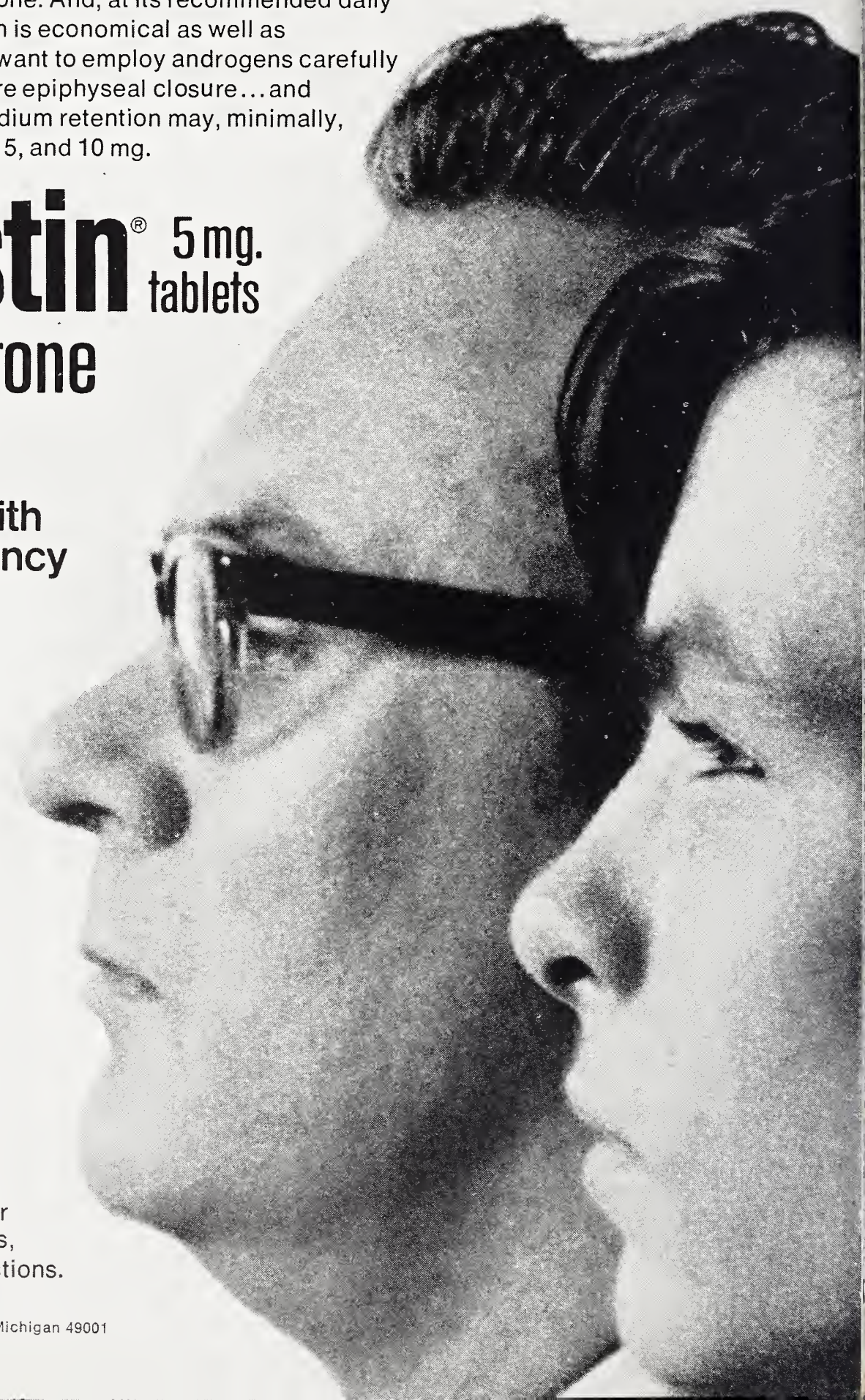
Hospital Staff Conference Set

The Medical Society of Milwaukee County and the Hospital Council of the Greater Milwaukee area will co-sponsor a Mid-America Hospital Medical Staff Conference June 19-23, 1972, at The Abbey in Fontana, Wisconsin.

The conference is designed for physicians, hospital administrators and trustees. Dr. C. Wesley Eisele, originator and director of the Estes Park-University of Colorado program, will conduct the conference.

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oral replacement with parenteral-like potency

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dications *Male:* Replacement therapy in testular hormone deficiency states. Prevents atroy of the accessory male sex organs following stration for as long as therapy is continued. potence and male climacteric symptoms when e to androgen deficiency. Primary eunuchoidn and eunuchism. Delayed puberty when eslished as not a simple familial trait. Indicated those symptoms of panhypopituitarism red to hypogonadism, however, appropriate renal cortical and thyroid hormone replaceent therapy remain of primary importance. *male:* Palliation of androgen-responsive, adnced, inoperable breast cancer in women beeen 1 and 5 years postmenopausal or women whom castration has shown the tumor to be rmone dependent. Prevention of postpartum east manifestations of pain and engorgement; ere is no satisfactory evidence that this drug events or suppresses lactation per se. In osporosis androgens may be of adjunctive lue to adequate considerations of diet, calum balance, physiotherapy and general health omoting measures. *Males and Females:* In the eatment of protein depletion states which ocir in geriatric patients, in debilitation states, in ronic corticoid therapy, resistant fractures; yptorchidism; creating a positive nitrogen balce, tissue repair and other anabolic effects. drogenic steroids may produce a response in lastic anemias, myelofibrosis, myelosclerosis, nogenic myeloid metaplasia and hypoplastic emias due to malignancy or myelotoxic drugs. drogens are not of value in other anemias.

ntraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, ostatic carcinoma, severe liver disease, severe rdiorenal disease and severe persistent hyrcalcemia.

ecautions Employ with caution in young boys avoid precocious sexual development and emature epiphyseal closure. Androgens tend promote retention of sodium and water, therere, watch for edema—particularly in the elderly. cidence and severity of edema have been inimal and have been associated only with gh doses used for palliation of breast cancer. ypercalcemia may occur, particularly in patients th metastatic breast carcinoma; if this occurs e drug should be discontinued. Changes in er function tests, such as increased BSP rention and SGOT levels, can occur during therpy. Jaundice has been rarely reported. If liver nction tests are altered, discontinue medicaon or reduce dose. Priapism is indicative of cessive dosage and is indication for temporry withdrawal of drug. When treating protein epletion states or osteoporosis, an adequate et should be provided and prolonged immobiliation avoided whenever possible. When treating lastic or hypoplastic anemias, androgen therpy should not replace other measure such as ansfusion, correction of iron deficiency, antiacterial therapy, and the use of corticosteroids.

dverse reactions Nausea, dyspepsia, menrual irregularities, hepatic dysfunction, priasm, edema, precocious sexual development, nd premature epiphyseal closure in young atients have been reported. *Male*—Prolonged dministration or excessive dose may cause hibition of testicular function with oligospermia nd decreased ejaculation volume. *Female*—arge doses or prolonged administration may roduce masculinization with signs such as hirutism, deepening of the voice, enlargement of ie clitoris, acne, and sometimes, increased ibido.

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Champus Claims Peak in Summer

CHAMPUS Fiscal Administrators received 200,695 claims during the month of June 1971, the highest monthly claim total in the history of the program. The claims total for July 1971 is not yet available but is expected to be even higher.

In the Medical Care Plans Department of MSMA, H. Cody Harrell, Assistant Executive Secretary and Comptroller, also reported that a record number of claims were processed and paid during this period in the Mississippi program.

Officials of the Civilian Health and Medical Program of the Uniformed Services explained that many CHAMPUS beneficiaries pay their medical and pharmacy bills directly to the provider of care and send the receipts or itemized statements to the Fiscal Administrator for reimbursement only at the end of the fiscal year. This practice causes a large increase in the number of claims received by the Fiscal Administration during the summer months.

The increased volume of claims coupled with their complexity (shoe boxes filled with receipts, itemized statements, prescriptions, etc.), has created backlogs in the offices of many Fiscal Administrators.

Last January CHAMPUS beneficiaries were asked to help prevent the traditional summer peak by making regular submissions to their servicing Fiscal Administrator. In some states this request apparently went unheeded, and the present avalanche of claims resulted. The backlog created by these year-end submissions will result in delayed payment of both reimbursement claims and payments made to participating providers.

CHAMPUS officials have asked beneficiaries to view any delayed receipt of payment with patience. They also note that beneficiaries can assist in preventing similar delays in the future by submitting claims on a regular basis throughout the current fiscal year after the annual outpatient deductible requirement has been met.

The deductible is $50 in charges for one beneficiary, not to exceed $100 per family for two or more beneficiaries who use the program. Submissions should be made every two or three months or more frequently when the value of the receipts or itemized statements exceeds $25 to $30.

Reimbursement claims for inpatient related care may be submitted at any time without regard to the outpatient deductible.

MIC Announces New Location

The Mississippi Interagency Commission has announced its new location in Office Plaza just west of Interstate Highway 55 North near Jackson's northern city limits. The M.I.C. suite is in the McGehee Office Annex directly behind Bourne-McGehee realty offices located in the 5300 Block of I-55 N. Access is from the Office Plaza entrance drive directly off Frontage Road.

The new quarters provide space to accommodate additional staff to serve the developmental disabilities program and to give increased emphasis to the development and coordination of child-related services.

The new mailing address is P. O. Box 16189, Jackson, Miss. 39206 and the telephone number is the same: 354-6692.

SMA Plans Miami Meeting

Dr. Albert C. Esposito, of Huntington, West Virginia, president of the Southern Medical Association, the largest regional medical association, and second largest general medical association in the country with members in Alabama, Mississippi, Arkansas, Florida, Georgia, South Carolina, North Carolina, Virginia, Tennessee, Maryland, Washington, D. C., West Virginia, Kentucky, Oklahoma, District of Columbia, and Louisiana, announces that plans have been completed for the 65th annual meeting to be held at the Fontainebleau Hotel, Miami Beach, Florida, Oct. 31-Nov. 4, 1971.

On Sunday evening, Oct. 31, 1971, there will be the president's reception honoring Dr. Albert C. Esposito. The Tuesday noon "President's Luncheon," will again honor the president. Guest speaker will be Dr. Merlin K. DuVal, Jr., the new H.E.W. assistant secretary for health and science.

On Wednesday morning, the Second General Session, with Dr. Esposito presiding, will include a symposium on "National Health Insurance," and guest speakers are Congressman Joel T. Broyhill, of Virginia, who is one of the primary sponsors of the present national health and insurance bills before Congress, and Dr. Carl A. Hoffman, of Huntington, West Virginia, AMA president-elect.

On Wednesday noon, the woman's auxiliary will have an outstanding "Doctor's Day" program, and on Wednesday evening, the association will honor Dr. Esposito with a dinner dance featuring the music of Lenny Dawson with Anita Bryant.

Thursday morning, the general session will present a symposium on "Medical Economics," and the business side of medicine, including pension and investment plans, office routines, and various factors of importance to the physician and his wife.

The 21 general sections have planned an outstanding scientific program with all the papers geared to the practical side of the practice of medicine in general practice, and each of the specialty sections. Each section has invited a nationally prominent guest speaker.

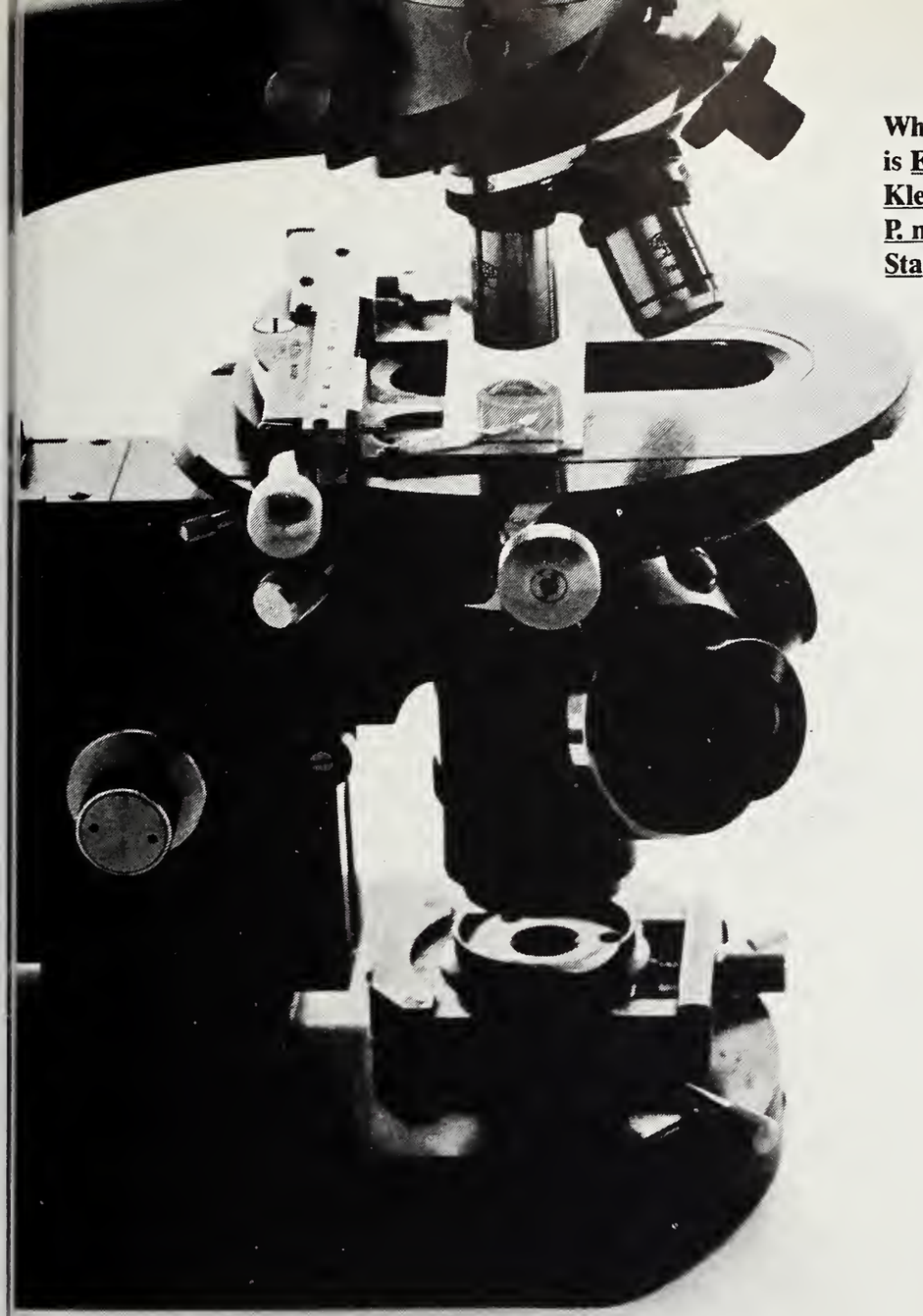
Medical students from the 34 medical schools in the Southern Medical Association area have been invited, as guests of the Southern Medical Association, to participate actively in the program. Also, at the meeting, the annual "Distinguished Service Award" and the original "Research Awards" will be presented.

Several medical societies will be meeting jointly with the association in November including the "American College of Chest Physicians" Southern Chapter; The Radiological Society of North America; The Southern Gynecological and Obstetrical Society, as well as alumni groups from all the medical schools in the South.

The meeting will conclude Thursday noon, when a post convention tour to Greece and the Greek Islands will embark. There is no registration fee, and all physicians and their wives are invited to attend.

Dr. Esposito, a past president of the West Virginia State Medical Society, the Cabell County Medical Society, and the West Virginia Academy of Ophthalmology, is also currently serving as the secretary of the American Association of Ophthalmology, as well as a vice-president of Blue Shield of West Virginia, member of the Executive Committee of Wespac, and the alternate delegate to the A.M.A. from West Virginia. He was this year the recipient of the "Outstanding Ophthalmologist Award" of the Southern Medical Association-Section of Ophthalmology.

Councilor to SMA from Mississippi is Dr. Raymond F. Grenfell of Jackson. Associate Councilors are Drs. Thomas A. Baines, J. Gordon Dees, and T. Scott McCay of Jackson, J. T. Davis of Corinth, and James T. Thompson of Moss Point.



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ndications: Acute, recurrent or chronic urinary act infections (primarily cystitis, pyelitis, pyelo-ephritis) due to susceptible organisms, (usually *. coli, Klebsiella-Aerobacter, Staphylococcus ureus, Proteus mirabilis,* and less frequently, *roteus vulgaris)* in the absence of obstructive ropathy or foreign bodies. **Important Note:** *In itro* sulfonamide sensitivity tests are not always eliable; tests must be coordinated with bacterio-ogic and clinical response. Aminobenzoic acid hould be added to follow-up culture media for atients already taking sulfonamides.

Currently, the increasing frequency of resistant rganisms is a limitation of the usefulness of anti-acterial agents including sulfonamides.

Free sulfonamide blood levels should be meas-ired in patients receiving sulfonamides for serious nfections since there may be wide variations with dentical doses; 20 mg/100 ml should be maxi-num total sulfonamide level, as adverse reactions ccur more frequently above this level.

Contraindications: Hypersensitivity to sulfona-nides, infants less than 2 months of age, preg-ıancy at term, and during the nursing period.

Warnings: Safety of sulfonamides in *pregnancy* has not been established. Sulfonamides will not eradicate group A streptococci. Deaths have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias associated with sulfonamide administration. Clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarities to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

Supplied: Tablets containing 0.5 Gm sulfisoxazole.

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ACC Admits Dr. H. H. Timmis

Dr. Hilary H. Timmis of Jackson has been granted Fellowship in the American College of Cardiology, the national medical society for specialists in cardiovascular diseases. The Mississippian is among a group of 61 from the United States and Canada recently admitted to the College's highest membership classification.

Dr. Harper K. Hellems of Jackson, ACC Governor for Mississippi, made the announcement.

The new Fellows have fulfilled stringent membership requirements based on several years of practice and specialty certification. This effort, according to Dr. Hellems, culminates in his being considered by colleagues in his community as a specialist or consultant in cardiovascular diseases.

SBH Offers Driving Course to Employees

Employees of the Mississippi State Board of Health are receiving training in defensive driving techniques in an effort to help combat Mississippi's rising number of highway accidents, announced Dr. W. E. Riecken, Jr., head of the agency's Accident Prevention Program.

The 8-hour National Safety Council Defensive Driving Course is being offered to the health department workers through the Mississippi Highway Patrol, with Tom Sadler, Director of Public Relations as coordinator. Sadler said the State Board of Health is the first state agency to make the course available to its employees.

Responsible for organizing and sponsoring the course for the Board of Health is Miss Mary Ann Elkin, supervisor of health education, along with Miss Valeria Logue, chairman of the Mississippi Association of Women Highway Safety Leaders, Inc.

The Defensive Driving Course is available to interested groups in the state through the Mississippi Highway Patrol, the Mississippi Farm Bureau and the Mississippi Safety Council.

Safe driving, according to Dr. Riecken, requires the adoption of an attitude toward operating a motor vehicle known as "defensive driving." He describes the defensive driver as an operator determined to take every reasonable precaution to prevent traffic mishaps, over and above what the law requires.

"The defensive driving course provides drivers an opportunity to learn what is involved in driving defensively, why and how various types of motor vehicle accidents occur, and what it takes to prevent them," said Dr. Riecken. "In short, drivers are provided with a standard of driving excellence which they can use to evaluate and improve their own driving."

New Instrument Removes Faulty Vitreous

A new instrument for restoring sight by removing faulty vitreous has been developed by a Miami surgical team.

The instrument and its use are described in the July-August issue of *Transactions,* official journal of the American Academy of Ophthalmology and Otolaryngology.

Before their technique was developed, explain Drs. Robert Machemer, Helmut Buettner, Edward W. D. Norton, and Miss Jean-Marie Parel, vitreous was removed via the front of the eye after the cornea was opened and the lens removed.

Vitrectomy, the removal of the vitreous, is necessary when it loses its normal crystal-clear transparency, usually because of internal bleeding; when it forms light-obscuring membranes; and in complicated cases of detached retina.

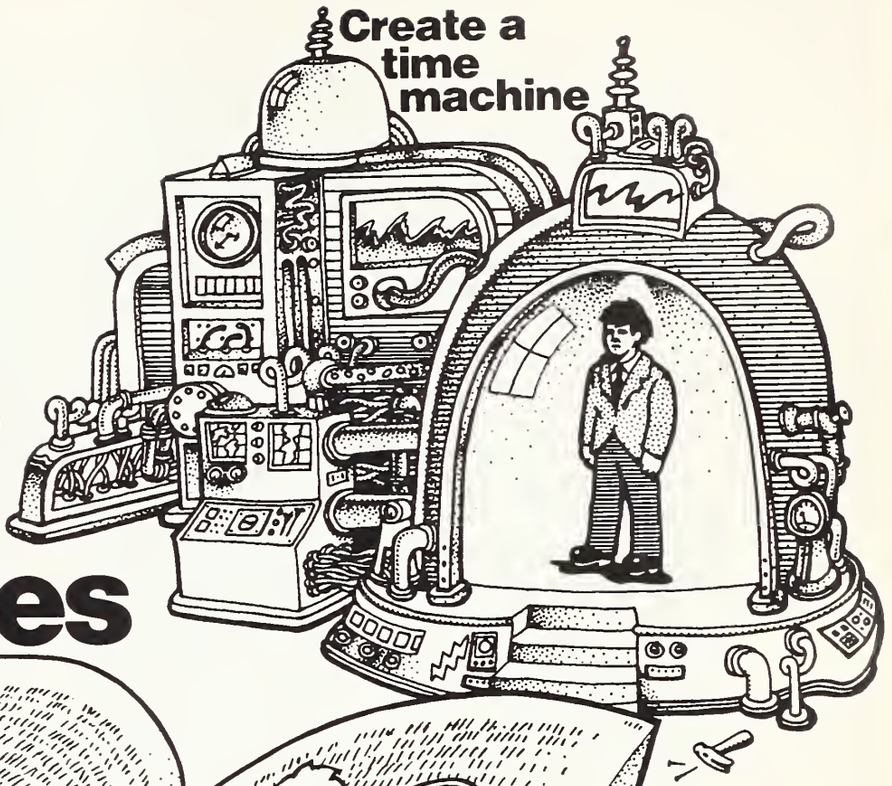
The instrument developed by the University of Miami team is the size of a writing pen. It tapers to a needle which is inserted into the side of the eyeball. This point is inserted into a small incision in the wall of the eye and penetrates into the vitreous.

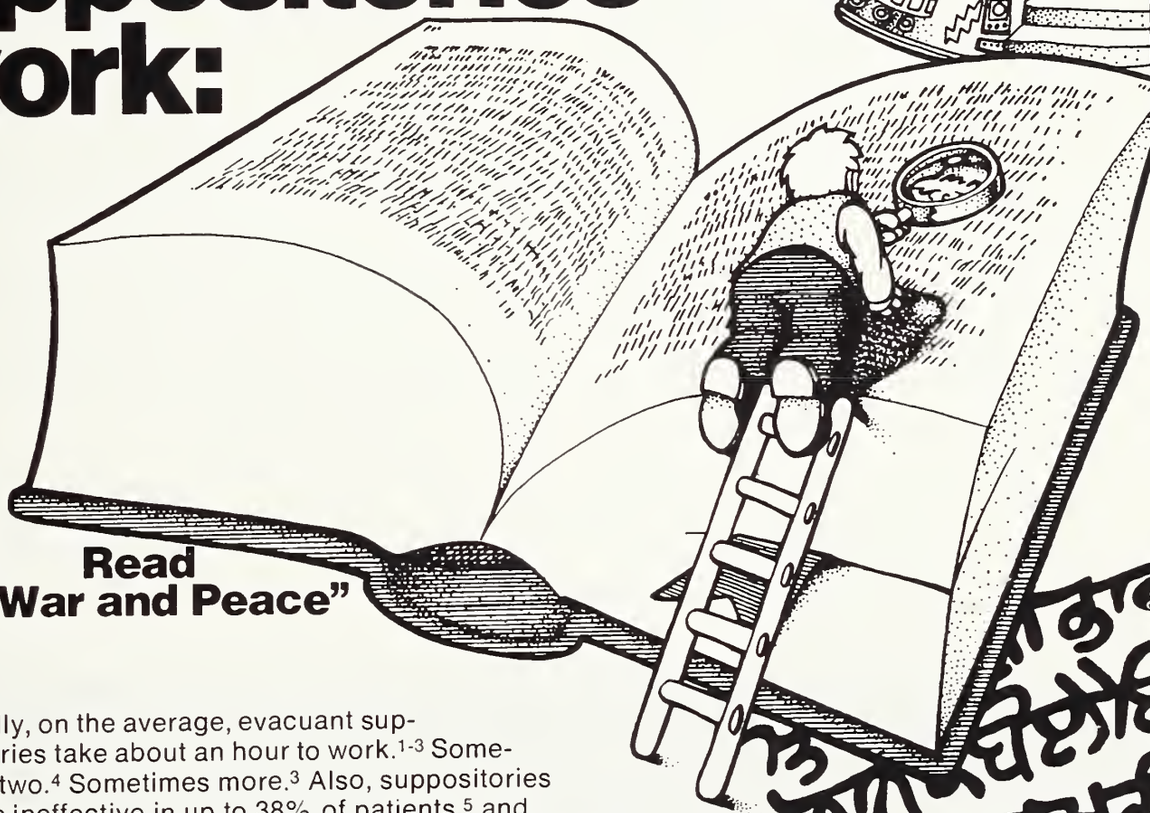
The needle is double chambered, and motor-powered, so that as it sucks vitreous out of the eye, it gently pumps in salt water to replace it and thereby maintains the eye's ball-like shape.

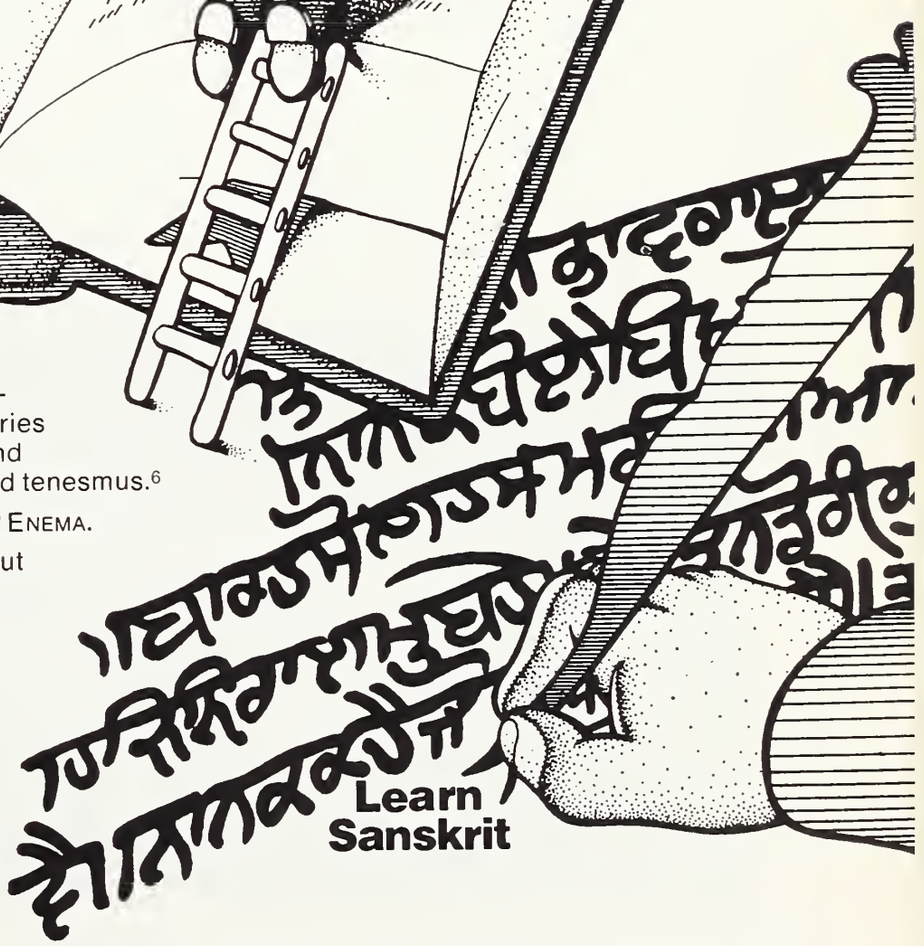
Control of this action is so delicate, that it can be reversed if the eye surgeon using it detects any further pulling away of the retina. During the entire procedure, the surgeon observes the inside of the eye with a special microscope focused through the eye's own lens.

In their report, the Miami researchers tell of four patients on whom the instrument was used: a 50-year-old diabetic man with hemorrhage in his eye and two women and a man with retinal tears.

What to do until suppositories work:



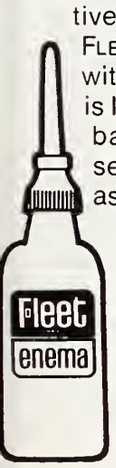




Actually, on the average, evacuant suppositories take about an hour to work.[1-3] Sometimes two.[4] Sometimes more.[3] Also, suppositories can be ineffective in up to 38% of patients,[5] and not infrequently produce smarting, burning and tenesmus.[6]

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FLEET ENEMA works within 2 to 5 minutes without pain or spasm. FLEET ENEMA induces a physiological pattern of evacuation, unlike purgatives and laxatives that may liquefy the stool. FLEET ENEMA avoids the irritation common with soapsuds enema. And FLEET ENEMA is leakproof: a rubber diaphragm at the base of the prelubricated tube prevents seepage and controls the rate of flow, assuring comfortable administration.



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Warning: Frequent or prolonged use of enemas may result in dependence. Take only when needed or when prescribed by a physician. Do not use when nausea, vomiting or abdominal pain is present.
Caution: Do not administer to children under two years of age unless directed by a physician.

References: 1. Blumberg, N.: Med Times 91:45, Jan., 1963. 2. Sweeney, W. J., III: Amer J Obstet Gynec 85:908, Apr. 1, 1963. 3. Weinsaft, P.: J Amer Geriat Soc 12:295, Mar., 1964. 4. Baydoun, A. B.: Amer J Obstet Gynec 85:905, Apr. 1, 1963. 5. Feder, I. A., Flores, A. and Weiss, J.: Amer J Gastroent 33:366, Mar., 1960. 6. Smith, J. J. and Schwartz, E. D.: Western J Surg 72:177, May-June, 1964.

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New Riverside Hospital Is Under Construction

Riverside Hospital, a facility for the treatment of adult psychiatric patients needing inpatient care, is now under construction on Lakeland Drive extension in Jackson.

A group of 15 psychiatrists formed Psychiatric Development Associates to construct the new hospital to meet the acute need for adult inpatient beds in the Jackson area. Completion is expected within 11 months, said the architect, R. P. Bob Adams of Jackson.

The facility will contain 56 beds separated into basic social units, said Dr. William C. McQuinn of Jackson, president and a member of the board of directors.

The basic social unit is just four private bedrooms around a common living room and bathroom. The patient does have his own room in which to retreat, but to watch television or go to the bathroom, he has to come out and at least pass another person, pointed out Dr. McQuinn.

Three basic social units, in a widening spiral, will be linked together around a library with a fireplace. To begin with, the hospital will include two of these 24-room treatment units. Patients from both sides will go to the cafeteria dining room for meals and will use the indoor game room, swimming pool and tennis courts. "This arrangement allows the patient peace but encourages social interaction," he said.

There will be an eight-room acute care unit which will probably serve as the admissions service for many patients, and a main building housing administrative and medical staff facilities, kitchen, food service, dining areas, storage and maintenance, and occupational and recreational therapy. Paved parking areas for staff and visitors will be provided.

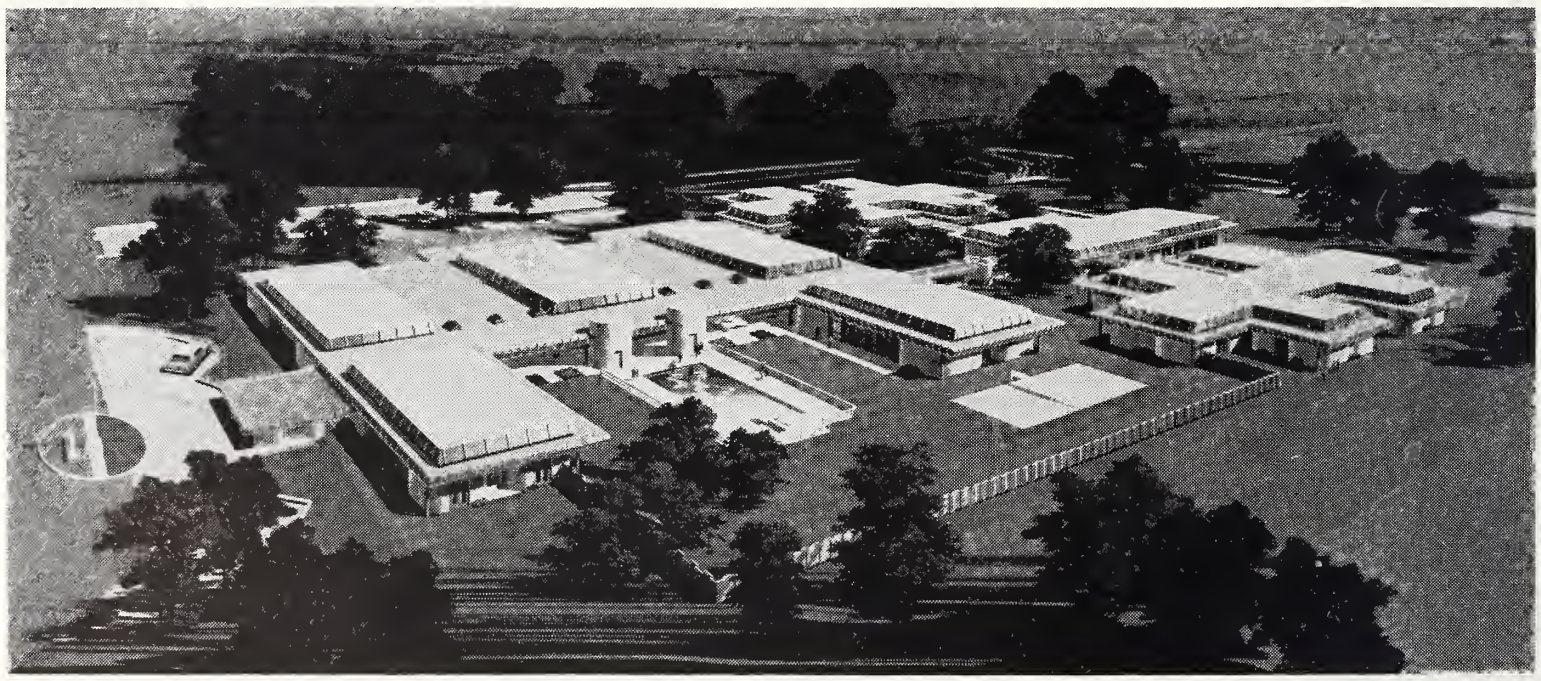
Some five years ago, the first scattered plans were laid for the new facility as a result of the area shortage in inpatient psychiatric beds. Psychiatrists now have to use the available beds in Jackson on a rotation basis. If a patient has to be hospitalized immediately, he often has to go out of state, said Dr. McQuinn.

The current situation is geared toward crisis intervention treatment which brings improvement in three to seven days, he added. For longer treatment, the present facilities are inadequate and confining.

With the campus type arrangement and covered walkways, patients at Riverside will have more opportunity for freedom and to get out and become involved in therapeutic programs throughout the day.

The arrangement will allow for a broad program and there will be no specific regimen of treatment. Each psychiatrist on the staff will be able to admit patients and to treat them in the way he feels to be most effective.

The psychiatrists involved hope to attract more of their specialty to the Jackson area when the new facility is completed and there will be an open staff policy. They expect to have office facilities adjacent to the hospital for psychiatrists in the future.



The artist's drawing of the new Riverside Hospital shows the basic social units joined by covered walkways to the main administration and treatment building.

The hospital will be accessible to all portions of Jackson with the interstate highway system. Future plans also call for developing a unit for children in the complex.

This will not be a long-term or custodial type of facility and alcoholic and drug cases will not be accepted. Dr. McQuinn estimates that the average patient will stay three to six weeks. If much longer is required, the directors feel a different setting would be more appropriate.

The board of directors and executive officers are Drs. McQuinn, Bruce M. Sutton, vice president, George C. Hamilton, secretary-treasurer, L. C. Hanes, Joseph E. Roberts, W. L. Waldron, and attorney Dan H. Shell, all of Jackson.

Conference Will Study Four Drugs

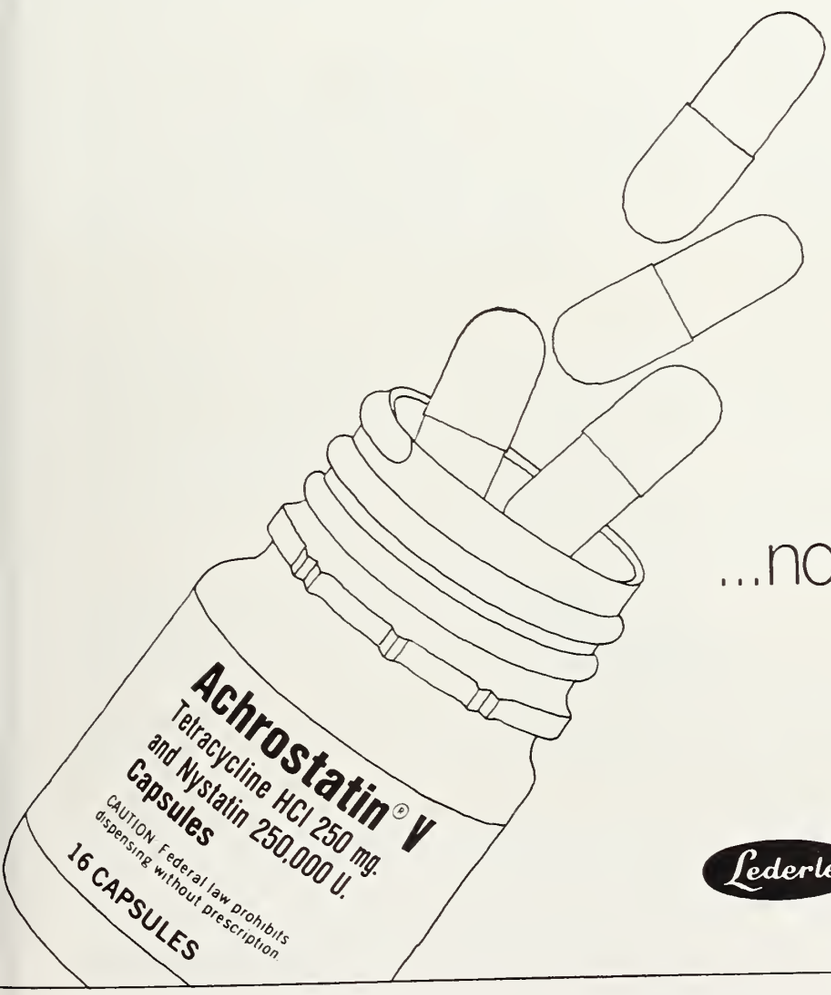
Dr. Thomas J. Macek, director of Revision of the United States Pharmacopeia, announces that the Conference on Bioavailability of Drugs, to be jointly conducted Nov. 22-23 by the U. S. Pharmacopeia and the Drug Research Board of the National Academy of Sciences-National Research Council, will consider case histories in the bioavailability of four drugs.

These drugs are phenylbutazone, diphenylhydantoin, nitrofurantoin, and sodium warfarin. Those attending the conference will be encouraged to contribute to the general discussion on each of these drugs and also, to discuss the bioavailability of other drugs of particular interest.

The case history approach is being used so that the theoretical and experimental aspects of the formal papers can be related to the practical problem of producing specific drug products to meet uniform criteria of equivalent activity.

Dr. Macek emphasizes that the conference planning committee recognizes that the problem of assessing bioavailability and standardization is complex. Official standards of performance are necessary, however, and first steps must be taken towards that end. It is expected that reasonable approaches and commitments will come out of this conference that will lead ultimately to official standards for bioavailability.

Registration forms may be obtained by writing to Robert H. Henry, Director of Professional Affairs, United States Pharmacopeia, 12601 Twinbrook Parkway, Rockville, Maryland 20852.



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MIC Advisory Council Is Named

A planning and advisory council of 21 persons has been established to advise the Interagency Commission in formulating a statewide approach to problems of the developmentally disabled. The M.I.C. has been designated by Governor John Bell Williams as the official state planning agency for programs for persons with developmental disabilities—disabilities attributable to mental retardation, cerebral palsy, epilepsy or other neurological conditions found to be closely related to mental retardation or which require treatment similar to that required by mentally retarded individuals.

In announcing the appointment of the new council, Dr. Dorothy Moore, M.I.C. program director, said: "We are pleased that these highly qualified citizens and agency representatives have agreed to contribute their time to planning for the developmentally handicapped in Mississippi. Their knowledge and experience is expected to be of invaluable assistance in outlining needs, recommending program approaches and establishing service priorities for a comprehensive developmental disabilities program in the state."

Members of the council include representatives of the principal agencies and organizations concerned with services to the developmentally disabled, plus consumer representatives.

Agency representatives are: John H. Webb, director of the Division of Vocational Rehabilitation, State Department of Education; Thomas O. Prewitt, director of the field staff for the State Department of Public Welfare; Dr. Frank M. Wiygul, director of the Division of General Health Services, State Board of Health; Paul D. Cotten, Ph.D., director of Ellisville State School; Herman K. White, supervisor of special education for the State Department of Education; Homer P. Swayze, state manpower development training assistance coordinator, Mississippi Employment Security Commission; Martin F. White, medical social worker, Medicaid Commission; Dr. Robert D. Currier, professor, department of medicine (neurology), University of Mississippi Medical Center; Harry S. Scott, executive director, Mississippi Association for Retarded Children; James C. Wilson, Ph.D., chairman of the Department of Educational Psychology, Mississippi State University; Mrs. Esther Marshall, assistant professor of social work, Jackson State College.

Citizen representatives include: Ingram B. Schwann, Jackson, president of the Mississippi Council on Epilepsy; J. Roy Trim, Jackson, treasurer of the Mississippi Association for Retarded Children; L. O. Palmer, Jackson, vice-president, United Cerebral Palsy, Inc.; Mrs. Ethel Foster, Tupelo, president of the Lee County Association for Retarded Children; James Crawford, Meridian, executive vice-president of the Mississippi Jaycees; Jerome Lohrmann, Columbus, legislative chairman of the Mississippi Association for Retarded Children; Mrs. Ezra Towner, Marks, Quitman Center for Learning; Mrs. Hugh Purnell, Tupelo, president of the Mississippi Association for Mental Health; Mrs. John E. Mason, Gulfport, secretary, National Association for Retarded Children; Mrs. Delmer Edwards, West Point, commissioner, Region 7 MH-MR Commission.

CHAMPUS Aids in Government Recovery

CHAMPUS beneficiaries have assisted the government in saving several million tax dollars each year through recovery of the reasonable value of medical care from negligent third persons responsible for their injuries.

Under the terms of the Federal Medical Care Recovery Act, if a CHAMPUS beneficiary is injured and requires medical treatment because of the negligent act of someone else, then the government can recover, from the party who caused the injury or his insurance company, the value of the medical care received by the beneficiary.

A DA Form 1863-5, which is used to explain how the accident or injury occurred, is available at hospitals participating in the CHAMPUS for completion by the patient, sponsor, or other responsible family member in each instance that a patient is admitted for a bodily injury. CHAMPUS beneficiaries are urged to cooperate with the admitting hospital by promptly completing the form. The prompt completion and submission of the form to OCHAMPUS materially enhances the government's chance for recovery.

Hospitals and other treatment facilities will assist in completion of the form but most of the information required must come from the sponsor or the CHAMPUS beneficiary.

Legal officers of the Civilian Health and Medical Program state that submission of the form DA 1863-5 will not interfere with any cause of action the patient may have in his own right for injuries and damages caused by a negligent third party.

Apply Now for Leukemia Grants

Applications to support scientific research in leukemia and related disorders are now being accepted by the Leukemia Society of America, Inc.

Completed applications must be submitted before Nov. 1, 1971, for review in late Jan., according to Dr. Joseph H. Burchenal, vice president for medical and scientific affairs, and director of clinical investigation, Sloan-Kettering Institute for Cancer Research. Approved grants will commence June 1, 1972.

Four types of programs are supported by the Leukemia Society of America, a national voluntary health agency.

The *scholar program* consists of five year grants totalling $100,000 for individuals who have demonstrated distinct ability in the investigation of leukemia and related disorders.

The *special fellow program* is a two year award in amounts up to $15,000 and $16,000 per annum for investigators who have demonstrated ability in research and who have become interested in working in the field of leukemia and related disorders. This program may be individualized in recognition of the need for support of a variety of individuals intermediate between the Fellow and Scholar Programs.

The *fellow program* has two year awards of $9,000 and $10,000 per annum to promising younger investigators to encourage work in leukemia research.

The *small grant programs* includes grants up to $3,000 awarded in order to initiate new research programs. Grants are given only in exceptional circumstances.

Since its founding in 1949, the Leukemia Society has funneled more than $5,275,000 to 241 investigators. Currently, there are 52 Society grantees working in the fields of virology, chemotherapy and the basic sciences.

Applications may be obtained by writing the Vice President for Medical and Scientific Affairs, Leukemia Society of America, Inc., 211 East 43rd Street, New York, N. Y. 10017.

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Missouri Opens Med School at Kansas City

The innovative School of Medicine at the University of Missouri-Kansas City has opened its doors to what it termed "a new era of stressing care and compassion for patients" as it welcomed the first classes totaling 93 students.

Their initial day was marked with class visits to rooms of bedridden patients at six different hospitals throughout the city and tours of five other health-care facilities in the Hospital Hill area where the new UMKC Medical School is located.

The 53 students beyond Year 1 whose names were just made public plus the youngsters in Year 1 whose names were released last month were admitted to the unusual six-year program that emphasizes broad clinical competencies together with strong recognition of the sociological and psychological factors which accompany patients' illnesses.

The six-year program, consisting of 48 weeks in each of the first five years and 36 weeks in the final year, includes 40 Year-1 students—most of whom were graduated from high school just last June—in addition to 17 in Year 2, 23 in Year 3, and 13 in advanced standing. The average age of the freshmen is 17.8. Three are 16 years old.

According to Dean Richardson K. Noback and Dr. Andrew McCanse, chairman of the Council on Selection, the advanced standing students, who will complete their training in two to three years, number four Ph.D.'s—including two in pharmacology and one each in biochemistry and physiologic psychology. Still another is the holder of a doctor of dental surgery degree.

One of the innovative features of the new medical school is the classification of the young people in the six-year period as "provisional medical students" in their first two years. During this phase of their training, they will devote 25 per cent of their time to medical studies and actual patient-oriented situations on Monday, Wednesday and Friday afternoons, Saturday mornings, and 10 weeks in the summer.

The remaining 75 per cent of their schedule will be involved with liberal arts courses taken at the University's College of Arts and Sciences. From Years 3 to 6 they will continue with their humanities courses for 25 per cent of their schedule and increase their medical, clinical and community health involvement during the remaining 75 per cent of time. At the end of six years, they will receive both the baccalaureate and medical degrees.

Starting with Year 3, another new concept in medical education will be the docent system and team approach. The docent, who is a practicing physician and a university scholar, will be responsible for the same group of 50 students throughout their final four years. The group of 50 is divided into four smaller units of 12 to 13 students with three to four from each class. At present, the medical school has three senior docents. Ultimately there will be eight as the enrollment grows to 400.

Each of the docents also is responsible for a 20-bed unit in the Kansas City General Hospital and Medical Center Corporation, which serves as the Medical School's major teaching hospital. The school, in addition, has affiliate agreements with nine other hospitals in the city.

In the team approach, the medical students will make rounds not only with their docents, but also with a pharmacologist, sociologist, psychologist, nurse, and other auxiliaries.

Dr. E. Grey Dimond, provost for the health sciences at UMKC, outlined four advantages to the new medical school's approach: more doctors can be trained in faster time; the use of more hospitals and doctors in the community can reduce construction and staff costs; by putting students into problems with people earlier, they learn more quickly what medicine is really all about; and in taking liberal arts courses throughout the six years, the future doctor may develop into a better balanced person.

Dr. Dimond also said the involvement of the UMKC Medical School with the community and region made the new institution truly an open medical school and a community of scholars.

The new school now is quartered in the renovated former Research Hospital School of Nursing. Ground for a $13,284,300 medical school building is expected to be broken next January with occupancy scheduled for January, 1974. Also to be constructed will be a $25 million teaching hospital to replace the present General Hospital. The entire Hospital Hill complex facilities when completed will total about $100 million.

The opening day's orientation program included formal introductions of principal leaders, comments by Dr. Dimond and Dean Noback, docent group discussions, and walking tour of Hospital Hill buildings at Brothers of Mercy Extended Care Facility, Western Missouri Mental Retardation Center, General Hospital, the Medical Library, Children's Mercy Hospital, and the UMKC School of Dentistry.

Other activities included bus tours and visits at City Hall with Dr. Charles B. Wheeler, Jr., Mayor of Kansas City and former pathologist at General Hospital, Wayne Minor Health Center, Martin Luther King Hospital, Model Cities Health Center, St. Joseph Hospital, Jackson County Hospital, Research Hospital, Baptist Hospital, Loose Park for box lunch, UMKC's Volkder campus for visit with Chancellor James C. Olson and tour of Linda Hall Library, Menorah Hospital, St. Luke's Hospital, Kansas University Medical Center, Trinity-Lutheran Hospital, Rehabilitation Center and St. Mary's Hospital.

According to the recently released data on the 54 students beyond Year 1, the ages of advanced standing students range from 22 to 34. Their geographic distribution shows nine from Missouri, two from Kansas, and one each from Washington, D. C. and California. Two are female.

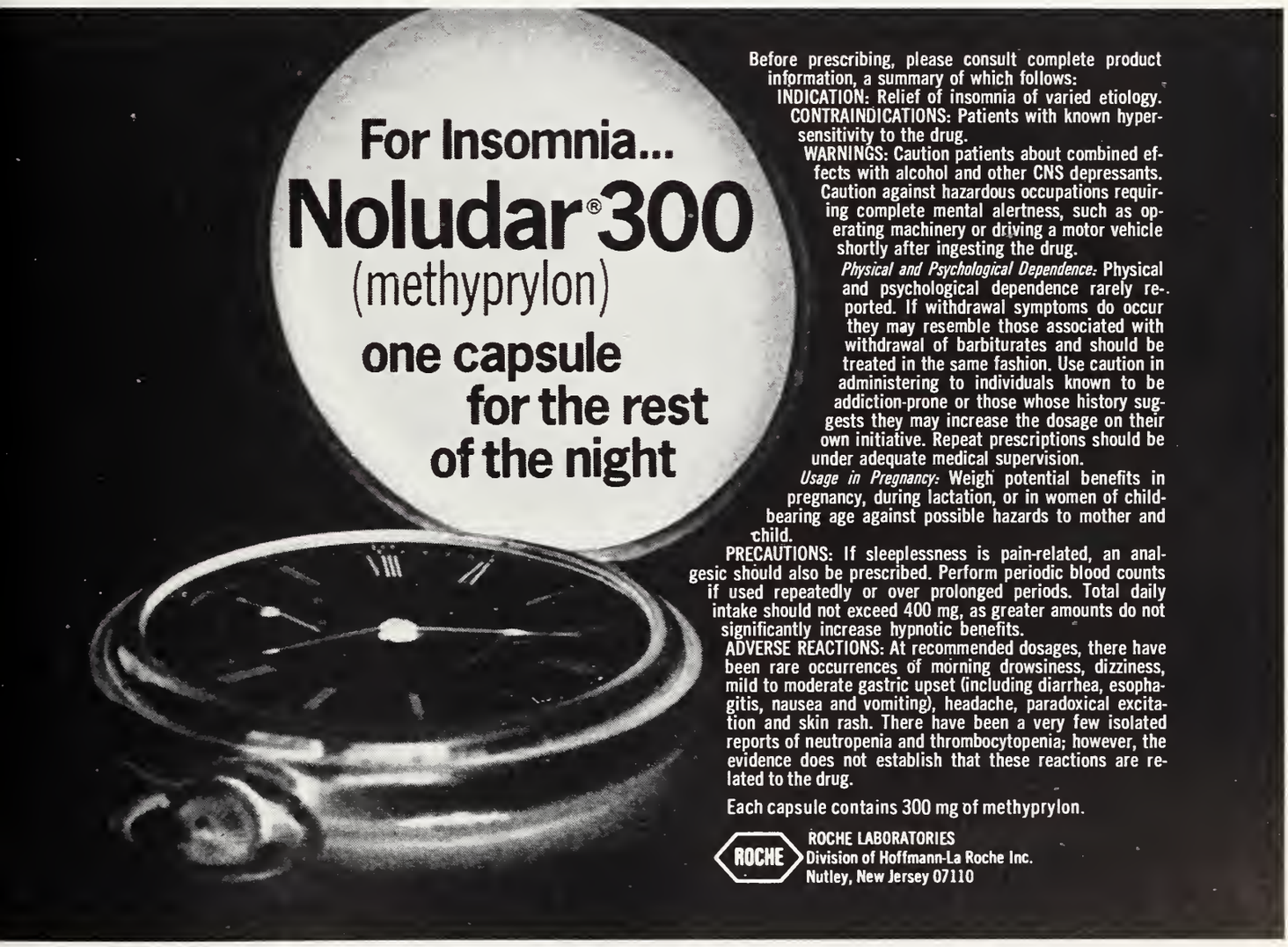
Ages of the Year 3 students, all from Missouri, range from 20 to 27. Six are females and two are black students who were counseled into entering the medical profession by the Metropolitan Area Talent Search program.

The Year 2 students range in age from 17 to 19. Two are women and one is Mexican American.

Occupational backgrounds of the parents of students in Year 3 and advanced standing reveal that among the fathers are seven physicians, three county employees, three salesmen, two executives, two engineers, two farmers, and one each as dentist, pharmacist, printer, pressman, supervisor, telephone company employee, machinist, retiree, and disabled person. Among the mothers are 24 housewives, four secretaries, and one each as nurse, social worker, school administrator, clerk, laborer, and seamstress.

The previously announced list of 40 Year 1 students include 10 women, or 25 per cent, and four black students, or 10 per cent. Both are above the national average of 11 per cent for women and 4.8 per cent for black students.

UMKC's Medical School will be one of five new medical schools opening this fall. The others are the State University of New York at Stony Brook Health Sciences Center; University of South Florida College of Medicine, Tampa; Rush Medical College, Chicago; and University of Nevada School of Medical Science, Reno. The combined enrollment for all five schools will be 374.



UMC Enrolls 95 Med Freshmen

University of Mississippi School of Medicine freshmen number 95, according to Dr. L. L. Sulya, Admissions Committee chairman.

Classes this year began on Sept. 1. The entering class represents 55 Mississippi towns and 21 colleges and universities.

Total school enrollment, said dean Dr. Robert E. Blount, is at an all-time high this fall.

NHLI Launches Hypertension Studies

In a major effort to bring to the community the fruits of years of research on high blood pressure, the National Heart and Lung Institute (NHLI) is starting pilot programs in nine communities to develop and evaluate different methods of detecting and caring for hypertensive persons in the population at large. NHLI is a component of HEW's National Institutes of Health.

Effective anti-hypertensive agents to reduce the high blood pressure itself are available. But research in the past has shown that these therapies must be applied continuously—often for many years of the patient's life—if the high toll of death and disability from the long-term effects of hypertension on the heart, brain, or kidneys is to be reduced as well.

Furthermore, one's blood pressure may rise and persist at abnormally high levels for many years without altering one's subjective sense of health until there is serious damage, typically a stroke or heart attack years later. This presents a massive problem of motivating and maintaining on therapy the many hypertensives who are known to be present in any large United States community. This problem is confronted in the first phase pilot programs by the nine clinical groups.

Phase I should take at least a year. About 300 or more hypertensives will be identified in each community by blood pressure measurements which are repeated in all individuals with high initial levels. Those with persistently high levels, or hypertension, will then be referred to various programs of medical care, health education, and periodic long-term follow-up. To identify the means necessary to achieve success in minimizing dropouts from this life and health giving program will be a major objective of program staffs. They will take corresponding steps to improve the participation, reducing the barriers as they are identified.

If enough of the hypertensives are willing to maintain their clinic attendance and continue medications during the pilot programs, Phase II efforts can be undertaken. The purpose would be to assess any community benefits of such programs in terms of reduced rates of death and disability in the cooperating members. To accomplish this requires not only enough time (e.g., the time-lag from onset of damaging pressure elevation to heart, kidney, or brain damage) but also enough cooperating members for a statistical demonstration of the benefits to the community. Thus, Phase II would take several years.

Dr. Herbert Langford, professor of medicine at the University of Mississippi Medical Center in Jackson, was awarded one of nine grants for the pilot programs.

Mr. E. F. Howard Joins SMA Staff

Elliot F. Howard has joined the staff of Southern Medical Association as administrative assistant. The appointment was announced by Robert F. Butts, executive director of the 20,000-member physician group.

Howard, a former lineman on the 1965-69 football teams of Auburn University, recently completed two years' active duty with the U. S. Army.

"We are proud to have a young man of his caliber join our staff," said Butts. "Mr. Howard's experience in management and sales, though brief, has been exemplary and will provide a solid base for his work with our organization."

During the past year Howard was stationed in Vietnam with the 101st Airborne Division. As post exchange officer, he supervised 110 employees and handled sales of $700,000 a month. He was honorably discharged in July as First Lieutenant.

A native of Millbrook, N. C., Howard holds the B.S. degree in business from Auburn University.

Headquartered in Birmingham, Ala., Southern Medical Association is comprised of physicians from 16 states and the District of Columbia. The organization's 65th Annual Meeting is slated for Nov. 1-4 in Miami Beach.

Vanderbilt Plans Pediatric Cardiology Meet

The Children's Regional Medical Center second annual autumn symposium on pediatric cardiology is set for Oct. 9, 1971, at the University Club Grill Room of Vanderbilt University School of Medicine in Nashville.

Dr. Thomas P. Graham, Jr., associate professor of pediatrics and head of the division of pediatric cardiology, is program coordinator. The program is acceptable for seven prescribed hours of credit by the American Academy of General Practice.

Tuition is $15.00 and local hosts are Dr. and Mrs. Eric Chazen, Dr. and Mrs. Joe Lentz, and Dr. and Mrs. David Thombs.

The symposium is designed to provide the physician whose practice includes infants, children or adolescents, with information regarding everyday problems in diagnosis and treatment of suspected heart disease. Each talk will be followed by an extended period for questions and comments from the audience, as well as discussion by visiting and Vanderbilt faculty.

A special program is planned for the ladies and tickets will be available to the Vanderbilt-Alabama football game that evening.

Lilly Defends Acidulin to FDA

Eli Lilly and Company has asked the United States District Court in Indianapolis for a declaratory judgment that the marketing of its product Acidulin® (glutamic acid hydrochloride, Lilly) is not in violation of the Federal Food, Drug, and Cosmetic Act. The company also sought a preliminary injunction against any action by the government to prevent the product's distribution.

The company estimated that at least 5,000 physicians have prescribed Acidulin in the last year for as many as 50,000 patients having hydrochloric acid deficiency in the stomach. Most of the drug's use is on prescription.

"There has never been any question about the safety of the product," a company spokesman said, "and we do not want to be in the position of depriving physicians and patients of a medication they have found useful."

The Food and Drug Administration had notified the Lilly company that continued marketing of Acidulin would be regarded as a violation of the Federal Food, Drug, and Cosmetic Act. The FDA relied upon an opinion of a panel of the National Academy of Sciences/National Research Council. The panel, reviewing a number of products that, like Acidulin, contain glutamic acid hydrochloride, questioned their effectiveness, but conceded that its view "is contrary to the opinion expressed in some current textbooks on gastroenterology."

The Lilly spokesman commented, "Where there is a difference of opinion among well-qualified physicians, the experience of prescribing physicians should be given due consideration before removing a drug that has performed usefully for 44 years."

The company said the significance of the product is in the field of therapy, not economics, since "the market is small in relation to total sales."

SSA Proposes New Medicare Regulations

Proposed new cost reporting regulations for Medicare providers should prove administratively advantageous both for providers and the Government, according to Robert M. Ball, Commissioner of Social Security.

The proposed regulations require hospitals, extended care facilities and other providers operating under Medicare to align their Medicare cost reporting periods with their annual Internal Revenue Service income tax or informational return reporting periods, and to adopt IRS due dates as the due dates for filing Medicare cost reports.

Ball noted that the proposed change, published in the *Federal Register,* would permit providers to base Medicare cost reports on data developed during management audits prepared in advance of filing their IRS returns, rather than on unaudited data which might later require correction to reflect audit adjustments.

Under present regulations, Medicare providers must submit an annual cost report covering a 12-month operating period. Selection of the period is at the discretion of the provider. It need not coincide with any 12-month period the provider has established for other purposes.

Currently all providers—except those operated by Government and certain other exempt organizations—must file an annual income tax or informational return with IRS. The proposed regulations would allow providers which are not required to report to IRS to continue to make their Medicare cost reports under present procedures.

The proposed regulations would be effective for cost reporting periods beginning after Dec. 31, 1971. Interested parties have 30 days from *Federal Register* publication date to submit their views and comments to the Commissioner of Social Security.

EEG-Neurophysiology Congress Scheduled

The eighth international Congress of Electroencephalography and Clinical Neurophysiology will be held Sept. 1-7, 1973, at Marseille, France. Headquarters for the congress will be the Faculte de Medecine of the Universite d'AIX-MARSEILLE.

Scientific exhibits and demonstrations, symposia and general scientific sessions will be presented. Simultaneous translation in French and English will be provided for portions of the scientific and didactic programs.

For further information, write the Secretary-General of the Congress, Mme le Dr. G. C. LAIRY, Laboratoire d'EEG, Hôpital Henri ROUSSELLE—1, rue Cabanis-PARIS 14°, France.

Plastic Surgeons Sponsor Course

The Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois College of Medicine will present Surgery of the Aging Face, Nov. 7-11, 1971.

Co-sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc., the course is offered in three segments to provide opportunity for an advanced continuous learning experience over a six-month period.

Preparatory work begins in October with patient management problems in facial plastic surgery, testing diagnostic analysis and management.

A five-day workshop featuring live color TV facial plastic surgery will be conducted Nov. 7-11, with follow-up patient management problems and evaluative feedback on participants' performance during the ensuing six months.

Preference will be given to surgeons actively engaged in teaching. Advance registration is necessary to activate phase I of the program.

Registration fee is $450. For further information, contact Dr. M. Eugene Tardy, Jr., Department of Otolaryngology, University of Illinois. 1855 W. Taylor, Chicago, Ill. 60612.

Drug Sales Continue to Grow

Sales of drug products, both ethical and proprietary, will continue to show strong growth through 1975, with the hospital playing an increasing role in ethical drug consumption, according to a revised Unit Dose Drug Packaging Report by Reynolds Metals Company.

The updated report, prepared by the market research department of Reynolds, is being made available to drug manufacturers, drug contract packagers and hospitals.

Based on interviews and original research, the report says that usage of single unit drug packaging will show increased penetration in all drug markets.

Unit packaging of hospital in-patient drugs is expected to increase its share of the market from about eight per cent in 1967 to about 81 per cent in 1975; its share of the out-patient, retail-prescription, physician-purchased market from about four per cent in 1967 to about 50 per cent in 1975; and its share of the proprietary market from about seven per cent to 38 per cent in the same time period.

In all three segments, unit packaging of oral solid drugs will show the greatest rate of penetration.

The increasing implementation of unit-dose drug systems in hospitals is the most important factor in this trend toward the unit package. Reasons for this include the strongly demonstrated need for improved safety and efficiency in hospital drug distribution. The major impetus to unit packaging for drugs consumed outside the hospital is the increase in safety and convenience.

The new report contains an addendum on the results of unit dose studies by a number of hospitals and firms including comments on reduction in medication errors, savings in nursing time involved in medication activities, reduction in drug losses and the costs involved in operating a unit dose system on a continuing basis.

Copies of the revised Unit Dose Drug Packaging Report will be made available to the pharmaceutical industry. Inquiries should be addressed to: W. G. Barker, market director, Packaging Division, Reynolds Metals Company, 6601 West Broad Street, Richmond, Va. 23261.

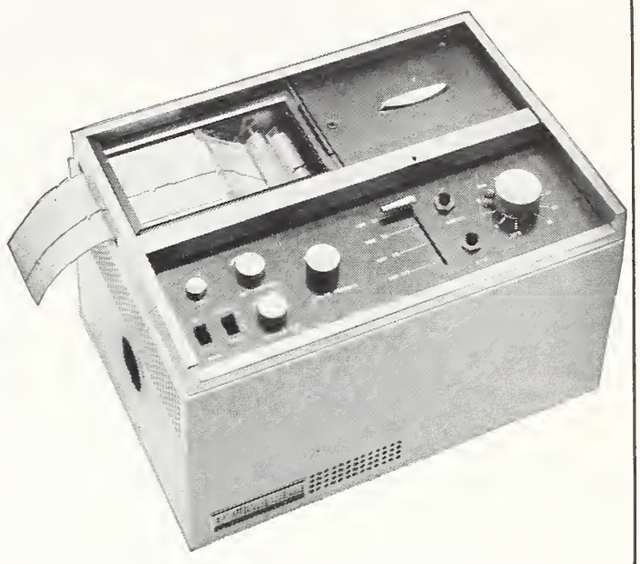
Reynolds, a major packaging supplier to the drug industry, produces a variety of plain, printed and laminated aluminum foil packaging products, including containers, pouches, labels, blister packs and cartons.

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IN CONCLUSION

A separate cabinet Department of Health, long a goal of AMA, got ne life when Rep. Paul G. Rogers (D.,Fla.) announced that he will intr duce such a measure. Concept is contrary to President Nixon's reor ganization proposals and tri-function HEW role now in effect. Heal expenditures by federal government are now second only to defense. Rep. Rogers' bill would also create committees on health in House c Representatives and Senate to oversee proposed cabinet department.

Popularity of bicycle riding in U.S. has more than doubled since 19 and estimates are that Americans own and ride 43 million two-wheele Said to have been invented in 1790, the bicycle is world's preferre means of transportation, especially in Europe and Asia. Use in U.S is more for recreation, as borne out by ratio of only one bike for every 2.4 automobiles. Medical authorities on exercise say that at 5 mph, cyclists burn an extra 4.5 calories per minute sitting still

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Sen. Philip Hart (D.,Mich.), only U.S. senator with a full beard, h reintroduced his "doctor merchant" bill in 92nd Congress. Measure aimed at preventing physicians from making any profit whatsoever on prescription drugs, whether supplied by physician or pharmacist. B could conceivably affect physicians authorized to dispense under Me caid and CHAMPUS, only two programs with inclusive outpatient Rx se vices. Hart measure has been unsuccessful in last several sessions.

AMA and Social Security Administration are in hassle over language used in Medicare "explanation of benefits." SSA, in cutting fees o physicians, says that charges are "more than allowable" or even rea- sonable, leaving impression that MD overcharged patient. AMA wants phrase "payment represents maximum financial responsibility of Medi- care" used. SSA Commissioner Robert Ball will not accept AMA word- ing, claiming it does not represent "reasonable charge concept."

Diabetes Detection Week is set for Nov. 14-20, and American Diabetes Association is again offering organization and information kits to component medical societies. Program is entirely physician-oriented and ADA asks that local medical societies take lead in sponsorship. Annually, more than half of local societies in Mississippi sponsor program in conjunction with other organizations. Kits are free from ADA at 18 E. 48th St., New York, N.Y. 10017.

Volume XII
Number 11
November 1971



JOURNAL of the Mississippi
STATE MEDICAL ASSOCIATION

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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $7.50 per annum; $1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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It's working, even when she's not.



10:30 p.m. To bed with tablets or suspension. Either dosage form of Gantanol® (sulfamethoxazole) provides reliable therapy for nonobstructed cystit

The convenient *b.i.d.* schedule lets the patient rest assured—while Gantanol fights the infection.

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In addition, Gantanol diffuses readily into interstitial fluids for antibacterial activity at the foci of the infection.



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Indications: Effective in acute, recurrent or chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) and in the absence of obstructive uropathy or foreign bodies. *Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media of patients receiving sulfonamides. Resistant organisms present a current problem to the usefulness of antibacterial agents. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Sulfonamide hypersensitivity; infants less than 2 months of age (except adjunctively with pyrime amine in congenital toxoplasmosis); pregnancy at term a during nursing period.

Warnings: Safe use in pregnancy has not been esta lished, and teratogenicity potential has not been thoroug investigated. Sulfonamides will not eradicate or prevent quelae to group A streptococcal infections, *i.e.*, rheuma fever, glomerulonephritis. Deaths from hypersensitivity rea tions, agranulocytosis, aplastic anemia and other blood d crasias have been reported; early clinical signs such as sc throat, fever, pallor, purpura or jaundice may indicate serio blood disorders. Complete blood counts and urinalysis w careful microscopic examination are recommended frequen during sulfonamide therapy. Clinical data are insufficient prolonged or recurrent therapy in chronic renal diseases children under 6 years.

Precautions: Use with caution in patients with impair renal or hepatic function, severe allergy, bronchial asthn and in glucose-6-phosphate dehydrogenase-deficient in

NEWSLETTER

November 1971

ar Doctor:

acticing physicians are almost unanimous in protest of Social curity Administration's Medicare patient survey ploy. SSA has dered Part B carriers to send questionnaires asking if services lled by MD were actually rendered. Action clearly clouds high tegrity of profession, at least suggests that such practice is evalent, although fraud has been almost nonexistent in program.

Look for formal action in registering protests by state and component medical societies. Impropriety of action is demonstrated by state medical association's 14 years experience with CHAMPUS with only two instances of irregularities in thousands of claims and millions of dollars.

spite successes in measles immunization, Public Health Service's mmunicable Disease Center estimates increase of incidence in 1971. DC says that there will be total of 80,000 cases, contrasted with ly 22,000 cases in 1969. Resurgence is attributed to declining vels of immunization in inner cities and rural areas. Level of mmunity has declined to 41 per cent from 61 per cent in 1969.

almost total ban on prescribing amphetamines has been called for Oklahoma State Medical Association. In letter to 2,300 members, sociation asked for moratorium except in cases of clear indication ch as narcolepsy and hyperactive and brain-damaged children. In rlier action, Louisiana State Medical Society called for similar tion, also in effort to stem tide of drug abuse.

dical Association of Alabama is improving care delivery to near-or in new statewide health insurance plan. Incentive furnished carriers is tax deduction on premium levies allowed by act of gislature. Participation by companies is voluntary, and Medicaid cipients will be excluded. State association will monitor care ality and charges through peer review.

mplete mailing of 1972 dues statements has been made to membership gain furnishing one-payment convenience and tax records. Included as application for membership in Mississippi Foundation for Medical are which is dues-free. Early response is encouraged to level peak f staff work in preparation of 1972 records and to assure documentation of tax deductions for members.

Sincerely,

Rowland B. Kennedy
Executive Secretary

ACCP Publishes Fungus Infection List

The increasing incidence of some pulmonary fungus infections has led the American College of Chest Physicians (ACCP) to publish a list of diagnostic recommendations and criteria to help physicians diagnose these ailments. The 8,500 members of the ACCP include specialists in both cardiovascular diseases and pulmonary diseases.

The diagnostic criteria are designed to help physicians to distinguish between infections of the lungs due to fungi and those due to other causes. "It is well known to the chest physician," the College's report in a recent issue of its journal, *Chest,* states, "that mycotic diseases involving the lungs frequently induce clinical symptoms and radiologic pictures indistinguishable from those produced by bacteria, viruses or carcinoma in its various forms."

The College's Committee on Fungus Diseases calls the criteria a "modus operandi" for the diagnosis of pulmonary fungus infections. It urges doctors to seek positive identification of such infections with laboratory tests and gives specific directions for obtaining sputum samples, bronchial aspirations and biopsies so they will yield evidence of prevailing fungus infection.

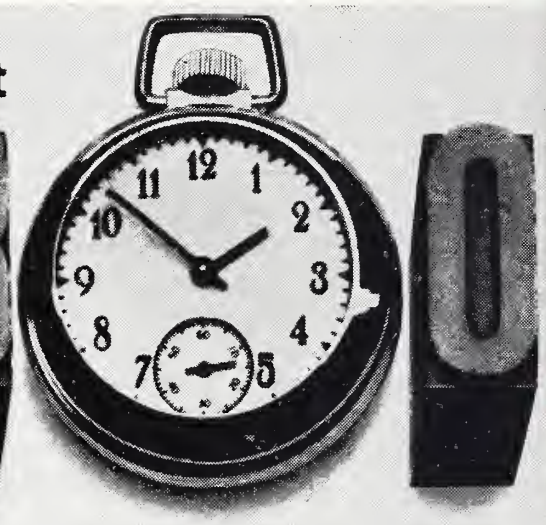
ACS Schedules 1972 Sectional Meetings

The American College of Surgeons has scheduled three sectional meetings in 1972: Jan. 17-19, Miami; Feb. 14-16, St. Louis; March 13-15, Philadelphia, the annual combined meeting for doctors and nurses.

All doctors of medicine may attend ACS meetings. Surgeons of outstanding ability will focus attention on newer ways of handling surgical problems through panels, symposia, "How-I-Do-It" clinics, scientific papers, and selected films. Each meeting features sessions in general surgery plus two or more surgical specialties.

For Insomnia... one capsule for the rest of the night

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Before prescribing, please consult complete product information, a summary of which follows:
INDICATION: Relief of insomnia of varied etiology.
CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.
Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.
Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.
PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.
ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

Each capsule contains 300 mg of methyprylon.

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DATELINE

ıg Industry Will ght Addiction

Washington - Senior executives from 28 of the nation's largest drug manufacturers appeared before House Subcommittee on Health to pledge all-out fight against drug abuse. Speaking under sponsorship of e Pharmaceutical Manufacturers Association, the industry leaders ported organization of scientific task force for research with phasis on products which can be addictive. Program was described "completely positive" commitment of the drug industry.

R Reports on liation Sources

Chicago - American College of Radiology reports that 46 states have laws regulating ionizing radiation and that remainder control it under neral health laws. College estimates that there are 106,000 medi- l x-ray units in U.S. and about 106,000 for dental purposes. Most e registered with state jurisdictions, and 61 per cent of medical its have been inspected. Twenty-three states, including Missis- ppi, have radiation control pacts with Atomic Energy Commission.

---

v High Reported Health Coverage

New York - In its 25th Annual Survey, Health Insurance Council found that 92 per cent of Americans under 65 have some form of health coverage th 94 per cent of those covered having surgical benefits and 80 r cent, medical benefits. Nearly 76 million have some form of major dical coverage, and total benefits paid in 1970 was $16 billion. west growth field, HIC reports, is dental insurance now extending 6.6 million Americans.

---

rvice Academy ll Gets Okay

Washington - The House Armed Services Committee rebuffed medical educators, AMA witnesses, and others by unanimously approving bill to create S. Armed Services Medical Academy. Almost every witness, except ose from Defense Department, opposed medical academy, urging that pport be given instead to existing medical schools. Some Capitol ll observers believe bill will pass House of Representatives but ll run into trouble in Senate.

---

inics Offer New alth Care Plan

Cleveland - The American Association of Medical Clinics has thrown its hat in the national health insurance ring with unique program of nationwide oup practice. Claiming that plan will require neither federal funds r any new enabling legislation, AAMC calls for local "trusteeships" medical and lay leaders, unification of care facilities, and uni- rm patient records kept by super computers. Present medical care nancing mechanisms would be utilized.

HAPPINESS IS A DEAD PINWORM



Mintezol® is nonstaining

MINTEZOL®
(THIABENDAZOLE [MSD])

SUSPENSION, 500 mg per 5 cc

You'll rely on MINTEZOL (Thiabendazole, MSD) often for pinworm disease. Not just because that's a very common helminthic infestation, but because MINTEZOL has such a high degree of efficacy.

MINTEZOL also provides an unusually wide range of action—against threadworm, hookworm, whipworm, and large roundworm disease. This broad spectrum of activity makes it particularly effective in these mixed worm infestations.

MINTEZOL isn't a dye. So you won't hear complaints about stained teeth, clothing, or bed linen. The most frequently occurring side effects have been anorexia, nausea, vomiting, and dizziness.



Contraindications: History of hypersensitivity to thiabendazole.

Warnings: May impair alertness; operation of automobiles and other activities made hazardous by diminished alertness should be avoided. If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed; erythema multiforme, including Stevens-Johnson syndrome (with a fatal case), has been associated with thiabendazole therapy in children. Safe use in pregnancy or lactation has not been established.

Precautions: Since thiabendazole is metabolized in the liver and excreted by the kidneys, hepatic and renal function should be carefully monitored in patients with dysfunction of these organs.

Adverse Reactions: Frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, collapse, abnormal sensation in eyes, blurring of vision, hyperirritability, numbness, hyperglycemia, xanthopsia, enuresis, perianal rash, cholestasis and parenchymal liver damage, hypotension, and a transitory rise in cephalin flocculation and SGOT. Hypersensitivity reactions include: fever, facial flush, chills, conjunctival injection, angioedema, anaphylaxis, skin rashes, erythema multiforme (including Stevens-Johnson syndrome), and lymphadenopathy. Appearance of live Ascaris in the mouth and nose has been reported on rare occasions.

Some patients may excrete a metabolite which imparts an odor to urine, much like that which occurs after ingestion of asparagus. Crystalluria without hematuria has been reported on occasion, but has promptly subsided with discontinuation of therapy; while the etiologic role of thiabendazole has not been established, the possibility of crystalluria should be kept in mind. Transient leukopenia has been reported in a few patients, but the cause and effect relationship in these cases has not been established.

NOTE: In children weighing less than 30 pounds, clinical experience with thiabendazole for treatment of intestinal parasitosis has been limited. Thus, the benefits of this therapy should be weighed against the possibility of adverse reactions.

Supplied: Suspension, containing 500 mg per 5 cc, in bottles of 120 cc.

For more detailed information, consult your MSD representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD MERCK SHARP & DOHME

New Gonorrhea Drug Enters U. S. Market

A new agent to help control the soaring incidence of gonorrhea is now available to the medical profession. The agent is Trobicin, a chemically unique antibiotic used specifically for treating acute gonorrhea, and being marketed by the Upjohn Company.

Venereal disease experts have said that gonorrhea has reached epidemic levels in the U. S. and is "out of control." The incidence of gonorrhea climbed 16 per cent in the U. S. last year, according to the U. S. Public Health Service's Center for Disease Control in Atlanta, and made similar advances in several other countries.

Not only have changing sex mores contributed to a surge in gonorrhea incidence since the mid-1960's, but some strains of the bacterium *(Neisseria gonorrhoeae)* have shown an increased resistance to penicillin and other antibiotics traditionally used to combat the disease.

Trobicin (spectinomycin), discovered in the Upjohn research laboratories in 1957, is structurally distinct from other antibiotics. Strains of the gonococcus resistant to other antibiotics have been found to be susceptible to Trobicin. In controlled clinical trials, the new antibiotic has produced cure rates of 96 per cent in men and women. These have been achieved in patients with new cases of gonorrhea, reinfections, and in cases where other antibiotics did not provide cures.

Less than 1 per cent of the people treated experienced any side effects from the single-dose treatment. The side effects included transient soreness and itching at the infection site, dizziness, nausea, chills, fever and insomnia.

In clinical trials using recommended doses, Trobicin effected cure rates of 96 per cent in men and women. The combined results from 14 investigators totaled 865 patients with 830 cures. A cure was defined as a patient remaining bacteriologically free from the gonococcus after treatment —for at least seven days in women and at least two days in men.

To date, no Trobicin-resistant strains have been demonstrated when the drug is given according to the recommended regimen. The new Upjohn antibiotic is given in a single intramuscular injection into the buttock. The dose is 2 grams for men and 4 grams for women—usually in two injections at different sites.

Trobicin is not indicated for treatment of syphilis, and its safety in pregnant women or in infants and children has not been established.

SALUTENSIN®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg./ protoveratrine A, 0.2 mg.

Brief Summary of Prescribing Information—9-9/22/69.
For complete information consult Official Package Circular.

Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in postsympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

Adverse Reactions: *Hydroflumethiazide:* Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

Usual Dose: 1 tablet b.i.d.

Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

Service items pictured at right and Salutensin samples are available on request from your Bristol Representative or on written request.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
November 1971, Vol. XII, No. 11

ORIGINAL PAPERS

Peer Review: Inevitable Evolution in Our Quest for Quality of Care

MILLARD S. COSTILOW, M.D.
North Carrollton, Mississippi

PEER REVIEW has become American medicine's first priority and principal household word in the short span of two years. It has generated more committee activity, more reports, more debate, and very likely, more constructive action at all levels of medical organization than any unified effort of previous years. It is medicine's own creature, the brainchild of practicing physicians who, through their state medical associations and AMA, are nurturing it to a healthy maturity.

And while peer review, under that precise designation and association policy, has been with us in Mississippi a scant year and a half, it is the largest single association program in terms of continuing effort, committee work, leadership involvement, staff support, and expenditure of money.

There are as many definitions of peer review as there are individuals discussing it, but whatever the warp and woof of the words used to define it, the simple distillation of the terms means just one thing: Physicians—and nobody except physicians—continually reviewing, assessing, and evaluating the quality of medical care with a final goal of making it better.

Logically, this implies many things in terms of subordinate but nevertheless worthy goals, not the least of which is the assurance that the patient has all the care he needs, not less and certainly, not more, and it must be the best care which can be delivered. There is an economic side of the peer review coin, too, as clearly implied in overutilization, a wasteful drain on professional manpower, scarce and expensive medical facilities, and money—from whatever source—intended for the purchase of the care.

Physicians—and nobody except physicians—continually reviewing, assessing, and evaluating the quality of medical care with a final goal of making it better is the essence and substance of peer review. In the short span of a year and a half, this substantial and massive program has grown from a meritorious concept into the state medical association's largest single program.

Now, peer review prospers under Mississippi physician management and moves ahead, assisted by a grant to the association of $369,000 from the National Center for Health Services Research and Development. It is all a matter, the author summarizes, of taking better care of the patient.

Chairman, Committee on Peer Review, Mississippi State Medical Association.
Member, Board of Directors, Mississippi Foundation for Medical Care.

"Our names are labels, plainly printed on the bottled essence of our past behavior," wrote Logan Pearsall Smith. So peer review is the inevitable evolution for the physician. When the American Medical Association was founded at Philadelphia in 1847, the assemblage took only two actions: They agreed to upgrade medical education, and they adopted the *Principles of Medical Ethics*. Nor were these actions as disparate as they may seem, for the goals were clearly concerned with care quality, the circumstances under which it was provided, and the professional and economic relationships implicit in the care.

In 1955, the Mississippi State Medical Association established a Grievance Committee and encouraged each component medical society to name a similar committee at local level. Differences between physician and patient were the chief tasks of the committee, but the By-Laws also charged it "to assist in maintaining high levels of professional deportment . . . " in the interest of providing the best quality of medical care.

CHAMPUS

When the Congress enacted the original Military Medicare, now CHAMPUS, in 1956, the association qualified as fiscal administrator for Mississippi. The original contract between the Department of Defense and the association specified that "the association shall furnish a committee of physicians to advise and assist the Government in providing quality medical care and in determining reasonable fees." Thus, for purposes of an historic benchmark, began our work in peer review, albeit in a time and context which must now be viewed as elemental, in terms of peer review at its present state of development. Nothing but praise, it should be hastily added, can be given to our colleagues who have guided this superb medical care program over a decade and a half.

At the 100th Annual Session in 1968, the association's House of Delegates approved a program of Fee Review Committees for component medical societies. The concept contemplated an extension of the Grievance Committee into areas of alleged overcharge as well as guiding third party payment mechanisms in arriving at levels of just professional compensation. In practice, however, the fee review activity too often resulted in the medical society's operating a "professional laundry," destined to wash the occasionally soiled linen.

Meanwhile, the Congress enacted Public Law 89-97, Medicare and Medicaid, which became operational in 1966. The law specifically provided for utilization review by hospital staffs, medical societies, or external sources where local groups were unable or unwilling to undertake these tasks. It was at that point that professional review was written into federal statute. Additionally, Part A intermediaries and Part B carriers for Medicare were charged with utilization review functions. Medicaid regulations similarly prescribe review activities.

HEALTH INSURANCE UNIT

The government of Mississippi is also involved in review of medical care through the State Board of Health. Medicare provides for a state's designating an agency of government to survey and recommend approval or disapproval of medical facilities for use in the program. Then-Gov. Paul B. Johnson assigned this task to the State Board of Health which created its Health Insurance Unit. The Unit is also charged with assisting and monitoring utilization review under the program.

Our present—and we believe advanced—peer review program grew and evolved from this background under the leadership of Dr. James L. Royals, our 1969-70 president of the state medical association. During his term of office, he stressed care quality and review by physicians.

"I want no insurance company or third party judging me and my professional services," Dr. Royals said in speeches. "I want other physicians to review my services to my patients."

In his presidential address to the 102nd Annual Session in 1970, Dr. Royals said that "within our own ranks, we must develop a working system of peer review as an effective instrument of self-regulation.

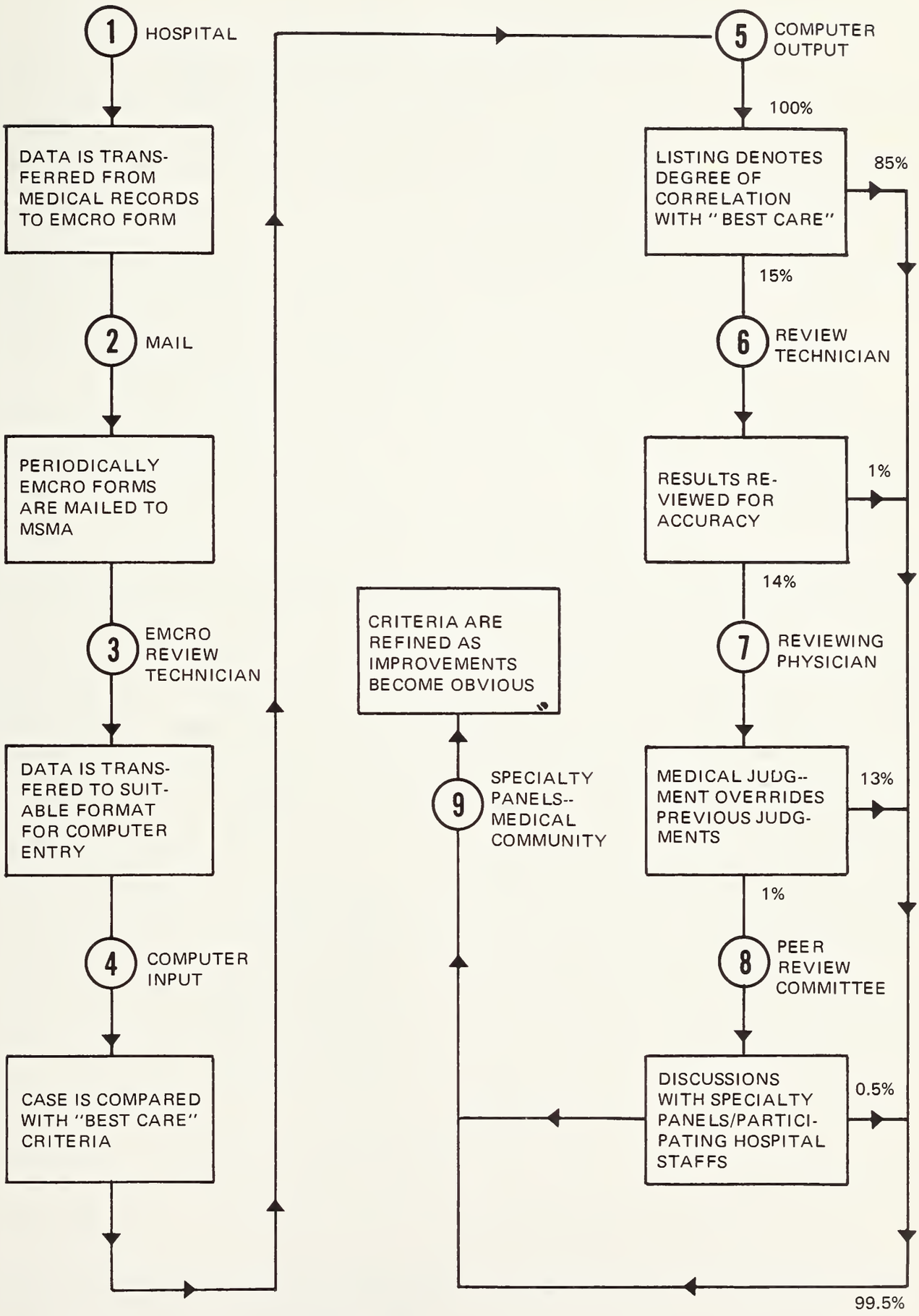
THE ALTERNATIVE

"The unacceptable alternative—and it is virtually upon us—is submission to third parties who would sit in judgment upon the quality of care and the price paid for it.

"Physicians are best equipped to make these judgments," Dr. Royals asserted, "but we must make responsible and worthy judgments if we are to have them accepted.

"Perhaps most important of all," he reminded the profession, "is the thrust of peer review which is not punitive but educational and corrective. We must learn to work in harmony with peer review and honor the judgments of our colleagues. Otherwise, we shall certainly be judged by others."

MSMA's EMCRO INPATIENT CARE STUDY REVIEW CYCLE



Critical path systems flow in Mississippi peer review program. Massive tasks of data handling are accomplished by specially trained staff, but all judgments and decisions are made by reviewing physicians or full Committee on Peer Review. Data bank is cumulative by disease entity.

In April 1970, just before the 102nd Annual Session, Dr. Royals appointed a nine-member *ad hoc* Committee on Peer Review. With less than three weeks in which to conduct its initial studies toward a program, the committee acted and reported to the Board of Trustees.

The Board gave the project support, and submitted a comprehensive report to the House of Delegates with the recommendation that "we propose to formalize this program into a single statewide endeavor with the broadest possible participation. . . ." The delegates agreed, abolishing the Grievance and Fee Review committees and gave the Committee on Peer Review constitutional status.

There followed a year of program development involving monthly meetings, staff and committee studies, out-of-state travel to regional and national meetings on peer review, and countless conferences with representatives of insurance carriers, the Blue plans, and agencies of state and federal governments.

A manual was written for interim guidance of component medical societies while the committee worked energetically at self-education and the crystallizing of a positive, constructive, and useful program within the frame of policy reference laid down by the House of Delegates. It became apparent to the committee that:

—Peer review should be conducted at state association level. It is a complex, extensive, and arduous activity field not easily adapted to and implemented at component medical society level.

—The first objective and primary thrust of this field must be care quality evaluation, education, and improvement. This goal and objective transcends all other aspects of the program.

CARE QUALITY CRITERIA

The committee, foreseeing an urgent need for physician-created yardsticks with which to measure care quality, embarked upon the task of drafting criteria. To be sure, these criteria are ideals and must necessarily take into account a wide range of acceptable courses while striving for sufficient specificity within a given disease entity and its treatment. We began to understand that we could not judge the "abnormal" unless we gained access to the full spectrum of the "normal."

In a nutshell, we felt that we should press toward the goal of reviewing all medical care rendered in Mississippi, realizing, of course, that attainment was improbable and that the task

PERIOD CONSIDERED 01/01/72 TO 02/01/72 — MISSISSIPPI STATE MEDICAL ASSOCIATION — CONSIDERED ITEMS FOR PEER REVIEW — PAGE 1

ITEM NO. 00001 — DOCUMENT NO. 002341 — PLACE/CARE 202 — STAFF MEMB. 21602 — PHYSICIAN'S DIAGNOSIS: ACUTE GASTROENTERITIS — PATIENT-IDENT: SVR2W 01 106428

ADMISSION INDICATIONS	PRESENT AT ANY TIME DURING HOSPITALIZATION
(1) SEVERE DEHYDRATION AND/OR ELECTROLYTE IMBALANCE	YES
(2) CARDIOVASCULAR COLLAPSE	NO
(3) PATIENT SIMULATE SIGNS OF ACUTE ABDOMEN	YES
(4) PATIENT SIMULATE SIGNS OF SEVERE SEPSIS	YES
(5) HOSPITALIZATION FOR DIFFERENTIAL DIAGNOSIS OF GI ENTITIES	NO
(6) PATIENT BLEEDING	YES
(7) DIABETES	NO
(8) INFANT OR NEWBORN	NO
(9) SPECIFIC ETIOLOGY REQUIRING ISOLATION TO AVOID CONTAGION	NO

SERVICES	CLASSIFIED	PERFORMED
(1) CBC AND URINALYSIS	USUALLY PROVIDED	YES
(2) STOOL EXAMINATION OR STOOL CULTURE	USUALLY PROVIDED	YES
(3) SERUM ELECTROLYTE STUDIES	USUALLY PROVIDED	YES
(4) FLAT PLATE OF ABDOMEN	USUALLY PROVIDED	NO *
(5) DIETARY RESTRICTIONS	USUALLY PROVIDED	YES
(6) FLUID AND ELECTROLYTE REPLACEMENT (PARENTERALLY OR ORALL	USUALLY PROVIDED	YES
(7) BUN	CONSISTENT WITH DIAGNOSIS	YES
(8) SIGMOIDOSCOPY	CONSISTENT WITH DIAGNOSIS	YES
(9) BLOOD CULTURES	CONSISTENT WITH DIAGNOSIS	YES
(10) AMYLASE OR LIPASE TESTS	CONSISTENT WITH DIAGNOSIS	NO
(11) FEBRILE AGGLUTINATION TESTS	CONSISTENT WITH DIAGNOSIS	NO
(12) BARIUM ENEMA	CONSISTENT WITH DIAGNOSIS	YES
(13) GALLBLADDER OR UPPER GI STUDIES	CONSISTENT WITH DIAGNOSIS	YES
(14) LIVER BATTERY	CONSISTENT WITH DIAGNOSIS	YES

RECOMMENDED DURATION OF HOSPITAL STAY (DAYS) 4.0 TO 7.0 DAYS
ACTUAL DURATION OF HOSPITAL STAY 6.0 DAYS

CONDITIONS FREQUENTLY PRESENT WITH THIS DIAGNOSIS THAT MAY EXTEND THE LENGTH OF STAY	PRESENT
(1) SHOCK	NO
(2) AZOTEMIA	YES
(3) BLEEDING	NO

DISCHARGE - ALIVE WITH APPROVAL DATE ADMITTED 12/26/71 DATE RELEASED 01/01/72 AGE 34 SEX M RACE- WHITE

REASON SELECTED - ' USUALLY PRUVIDED ' SERVICE NOT PERFORMED

Computer printout of case selected for physician review showing admission indications, services rendered, services not rendered considered usual to or consistent with treatment of condition. Physician, hospital, and patient identifications are coded, but all other data are written in narrative by computer.

MISSISSIPPI STATE MEDICAL ASSOCIATION
ANALYSIS OF MAJOR DIAGNOSES

PERIOD CONSIDERED
01/01/72 TO 02/01/72

PAGE 1

DIAGNOSIS ACUTE GASTROENTERITIS

PLACE OF CARE 201

NUMBER OF CASES DIAGNOSED BY STAFF MEMBER 02614	20
NUMBER OF CASES DIAGNOSED BY STAFF MEMBER 10220	13
NUMBER OF CASES DIAGNOSED BY STAFF MEMBER 30707	17
NUMBER OF CASES DIAGNOSED BY STAFF MEMBER 45020	04
NUMBER OF CASES DIAGNOSED BY STAFF MEMBER 64033	09
NUMBER OF CASES DIAGNOSED BY STAFF MEMBER 70555	11
	74

NO. CASES	CASES SELECTED	PER CENT	FAIL REVIEW	PER CENT	
74	5	6.7	1	1.3	THIS PERIOD
119	11	9.1	3	2.5	PAST PERIODS
193	16	8.8	4	2.06	TO - DATE

PERIOD CONSIDERED
01/01/72 TO 02/01/72

MISSISSIPPI STATE MEDICAL ASSOCIATION
HOSPITAL SUMMARY MATRIX

DIAGNOSIS ACUTE GASTROENTERITIS

	THIS PERIOD			PAST PERIODS			TO-DATE		
	NO. CASES	CASES SELECTED	PER-CENT	NO. CASES	CASES SELECTED	PER-CENT	NO. CASES	CASES SELECTED	PER-CENT
HOSPITAL 201	74	5	6.7	119	11	9.1	193	16	8.2
202	53	1	5.3	80	4	5.0	133	5	3.7
203	89	4	4.4	100	6	6.0	189	10	5.2
204	60	4	6.6	85	6	7.05	145	10	6.8
205	55	2	3.6	95	5	5.2	150	7	4.6
206	34	1	3.4	70	5	7.1	104	6	5.7
TOTAL	365	17	4.6	549	37	6.7	914	54	5.9

Summary of care rendered in reporting period for one diagnosis by the entire medical staff of one hospital. Cases selected for in-depth review are reflected. Summary analysis matrix compares clinical experience by review in other hospitals and total for review universe which is the state of Mississippi.

would be massive. It was at this point we recognized that we had a lot going for us in the association's 14 years of experience in administering the CHAMPUS program under physician management. We had a nucleus of a competent staff, a computer, data processing systems called software, and the latent capability of somehow bringing this ambitious project to fruition in the quest for continually improved care quality.

Apart from the committee, both the Board of Trustees and Council on Medical Service had devoted more than a year of study and discussion to foundations for medical care. Directing their attention to the California model best personified in the San Joaquin Foundation for Medical Care, the Board and the council came to identical conclusions that the need for a medical association-sponsored foundation was great in our state and that peer review should be its primary function.

Our separate labors coalesced in the House of Delegates at the 103rd Annual Session in 1971 with full approval of the committee's program and establishment of the Mississippi Foundation for Medical Care.

The program structure was now beyond the blueprint stage, but we realized its magnitude and understood that funding considerations imposed severe limitations upon development. At the moment, it was a question of incorporating the care foundation, getting it operational, and rendering services in order to finance the program. Then an incredibly fortunate opportunity came to us.

EMCRO BACKGROUND

The National Center for Health Services Research and Development of the U. S. Public Health Service invited each of the 54 state and territorial medical associations and the major metropolitan county medical societies to make an expression of interest in organizing an Experimental Medical Care Review Organization. The invitation offered funding to successful applicants. The Board of Trustees approved the proposal, and the Committee on Peer Review met a week after the 1971 annual session to advise and assist on the massive task of the application.

The protocol, a complex and lengthy document outlining the association's policies and proposals on physician-sponsored peer review, was written against a 12-day deadline and taken to Washington on May 24, 1971, by a single representative for presentation and the initial screening session at the National Center. Twelve applicant state

medical associations and major county societies were selected for final review to determine grant awardees, and we were among them.

Following a two-day meeting of the Board of Trustees, association representatives, including the committee chairman, went to Washington for appearance before a nonfederal review panel. The rest is history, and our EMCRO was funded for $173,890 during June 30, 1971, through May 31, 1972, and for $195,729 during June 1, 1972, through May 31, 1973. Two state medical associations, Hawaii and Mississippi, received these major awards. Lesser awards for EMCRO projects and feasibility studies went to Georgia and Utah and two major county medical societies.

Under the grant, the association has only the obligation to bring the peer review mechanism into being as proposed in its protocol and to publish our findings. The program is entirely that of the association. It is fully operational under the supervision of the Committee on Peer Review which, in turn, is responsible to the Board of Trustees. A new division in our headquarters executive staff organization has been organized to furnish the massive administrative support required. It has been designated the Division of Medical Care Plans and is headed by Mr. Hilton C. Bowers of Jackson, its director. He is a graduate of the U. S. Naval Academy and the holder of two earned master's degrees.

BASIC PREMISES

The basic premises of the Mississippi EMCRO or peer review program are:

—To evaluate comprehensively the quality of medical care delivered under tax-supported, federally-assisted, and other programs and financing mechanisms (including private, voluntary plans).

—To make suitable determinations as to medical necessity for such care.

—To make continuing examination as to the accessibility to quality care by all eligible and statutorily defined beneficiaries and by others in nongovernmental programs.

—To assure delivery of care in such programs based upon a framework of allowable and acceptable costs under usual, customary, and reasonable charges and/or reasonable per diem costs.

Considering that potential case review volume can easily mount to 500,000 to 1 million per year by 1973, analysis of the data and preparation for physician review are wholly dependent upon high speed computer processing against medically designed criteria. The base of our high speed, large capacity system is the new IBM 360/22 computer with disk and tape drives. It replaces the association's IBM 360/20 and possesses storage capacities for 22 million characters representing the disease entity, diagnosis, and treatment criteria, any one of which may be retrieved in millionths of a second. The data flow through the computer is 170,000 of these characters per second, illustrating the data processing power at our disposal.

Obviously, the data input will be massive and must necessarily flow into the computer at very high speed. To assist in this aspect, the new installation will have an optical reader which can accept 2,000 documents per hour, each consisting of a full condensation of a complete hospital chart. From this massive, complex information system will come our educational product for use by practicing physicians.

CRITERIA MANUAL

Our criteria, the physician-created yardsticks, originate with the respected Michigan and Pennsylvania review manuals. With the assistance of the Regional Medical Program of the University of Mississippi Medical Center at Jackson, these manuals were categorized by specialty for review by Mississippi specialty societies. Each responded promptly by appointing consultant panels for this purpose.

Giving our program the benefit of their expertise and advice were these Mississippi specialty societies and associations: Society of Anesthesiologists, EENT Association, Academy of General Practice, Society of Internal Medicine, Ob-Gyn Society, Orthopaedic Society, and Association of Pathologists.

Also, the Mississippi Chapter of the American Academy of Pediatrics, Psychiatric Association, Radiological Society, College of Surgeons, and Urological Association. Specialties not represented by societies in our state are consulted on an individual specialist basis. In each instance, the societies have considered only criteria for inpatient care of varying disease entities.

Generally, these criteria for probing review are constructed around parameters related to:

—Indications for hospital admission, including those requiring admission and those furnishing sufficient cause. Often, the indication may be a combination of such clinical circumstances.

—Services performed, including diagnostic tests, treatment regimen, probable length of stay, complications if any, discharge indications, and posthospitalization follow-up.

As the program becomes initially operational, five Mississippi hospitals with a total of 800 beds

are supplying data from charts for review. Participation is voluntary and bears the approval of each medical staff and the hospital management. In each instance, the data communications link is the medical records librarian who prepares input information on one of 60 forms, each for comprehensive analysis of a different disease entity. We will be adding about 12 new entities for review each month through early 1972.

The data are received and prepared for computer processing by a review technician, most of whom have the baccalaureate attainment and who are trained much in the manner of a claims adjudicator. From the medical records librarian's summary, the input document is prepared, using a template punched and coded for the disease entity being reviewed. Diagnoses are coded according to the *Eighth Revision, International Classification of Diseases, Adapted for Use in the United States*. Care procedures and diagnostic tests performed are coded in five digits, as prescribed by *AMA Current Procedural Terminology, 2nd Edition*.

FIVE-DIGIT CODE

Although the Blue plans and most insurance carriers continue to employ the 1956 and 1964 four-digit procedure codes, claiming that conversion to the new and more descriptive five-digit code is too expensive, our association converted to the new last April in a major reprogramming of software for CHAMPUS.

The committee was quick to recognize that were the EMCRO program limited to review of inpatient care under specialty panel criteria, virtually all outpatient and ambulatory care would be excluded from the project. What was needed was an inclusive review methodology which required nobody to prepare any special data. The obvious answer was the physician's claim form filed for payment under any insurance contract, Blue plan, or public care program.

A wealth of review data is in each such claim: The patient's name, age, and sex; identification of the attending physician; geographic location of the care; diagnosis; treatment; laboratory tests, when performed; x-ray, when done; frequency of outpatient services; and charges for the care rendered.

This highly flexible and near-universal review pattern will permit studies of outpatient care patterns, quality index, utilization of services, disease entities being seen, and costs.

To this point, we have established data sources on care rendered, a technologically advanced data processing system, specially trained staff, and physician-designed criteria. How shall we produce a product for physician review? How shall we select cases for review? Who will be the reviewing physicians? And, most important of all, what will be the educational product of this complex process for the practicing physician?

THE "NORMAL"

The vast majority of cases will reflect medical care of good and acceptable quality, delivered at just and reasonable costs, which involves neither underutilization nor overutilization. This is the "normal," and it becomes our data base. Moreover, it will grow in a cumulative manner as a computer-stored, comprehensive history which we can retrieve by any aspect at will and quickly.

The product will be the computer printout or hard copy. Beyond the cumulative, normal data base, an estimated 15 per cent of cases for review will be flagged as exceptions under the control criteria comparison. Here, we will go back and produce a detailed study of the case based upon one or more of these general exceptions:

—Absence of a required or sufficient indication for hospital admission.

—Lack of numerically significant or specialty panel designated indications for admission.

—Failure to perform services usually rendered for the diagnosis or those consistent with care of the condition.

—Performance of an unrelated or contraindicated service.

—Understay or overstay in the hospital.

—Length of stay influenced by a complication.

—Applicable factors of reasonable costs.

By no means are these general exceptions to be construed as the fully refined selection process which, for all practical purposes, will never be complete if we do our job well.

REVIEW PHYSICIANS

The printout, hard copy exceptions go to the review technician and EMCRO director. But remember, they are nonphysicians, so theirs is a communications—not an evaluation or judgment —task. The EMCRO grant budget provides for 1,176 hours per year for review physicians compensated at $15 per hour or $120 per day, plus transportation. The committee contemplates their serving on a rotating basis, and they will be selected from among all participating physicians in Mississippi.

In most instances, the review physician present that day will resolve the exception detected by the criteria application. His findings will also

be made a part of the history, both as an explanation and for education. Where the review physician is unable to resolve the exception or where there is notable exception as to care quality and other review considerations, he will forward the case to the committee for review at its monthly meeting.

Of course, the system is not and will not be error-free. Provision has been made for re-entering kick-out cases with correction of administrative errors, for detecting transposition mistakes, and for identifying faulty data. This, too, will be refined as the system and program benefit from experience.

The budget further provides for district utilization review consultants who will be available to visit hospital staffs and even individual practitioners in connection with the review program and continuing educational effort. They will be compensated for their services.

But the chief educational products will be line-item data analyses and selected cases sent periodically to the medical staffs of each participating hospital. These reports, and the series and variety will be substantial, will pertain to care given only in the participating hospital to which they are sent, and they will possess these desirable characteristics:

—Neither patient nor physician will be identified other than by code.

—The report will be a printed narrative utilizing spelled-out medical terminology. There will be no codes to look up and interpret.

—The reports will be related to the hospital to which sent but will also compare the hospital to the performance of the universe of the study, the entire state of Mississippi.

—The cumulative data bases will be reported by disease entity for the entire universe of the study.

EDUCATIONAL OPPORTUNITIES

No practicing physician need be reminded of the priceless educational opportunities offered by such detailed reporting and comprehensive scientific information system. This is why, incidentally, the committee was not astonished when far more hospitals applied for inclusion in the initial phase of the studies than we were able to accept.

But much of the educational product of the quality review program will be gleaned from non-institutional, outpatient care, so who sees this and how is it communicated? The committee is considering a variety of communications media, including the JOURNAL, regional reporting to practitioners through their respective hospital staffs, and periodic, separate publication. A desirable goal is to supply the individual physician with his own outpatient cases on a personal and private basis, giving him also regional and statewide comparisons against which to compare his own practice.

So this specialized, scientific, confidential, and comprehensive program is aimed squarely at:

—Professional education, intended to be useful, corrective where appropriate, nonabrasive, and timely.

—Third party care financing guidance, offering data on cost-effectiveness of quality care and realistic budgeting for care purchase.

—Medical facilities and institutions, a new and unique management tool stressing quality and optimum utilization, sorely needed because of costs.

—Improving access to medical care by identifying patterns, utilization factors, frequency of diagnoses, morbidity and mortality, and demographic considerations, all enabling the association or its foundation for medical care to approach private and public sources of care financing with solid information upon which to base new and constructive innovations.

OTHER BENEFITS

And when all of this is fully operational, there are still opportunities and yet unrealized benefits in extension of our physician-sponsored review program. We can perform useful services examining care in ECFs and nursing homes. Availability and utilization of allied professional services, such as physical therapy, home health services, clinical psychology, medical social workers, and the like could be patterned for study. Needed? Yes, we know so little about this now, and it does relate to medical care and practice patterns.

Uncontrolled—sometimes runaway—utilization in prescription drug programs is highly appropriate for review. In Mississippi Medicaid, for example, Rx drugs were the single largest item of expense in the first full fiscal year of operation. On per cent of expenditure in the $41 million state program, drugs were 24, nursing homes were 23, inpatient hospital care was 18, physicians received 15, and all other services accounted for 20 per cent.

The state medical association administers and reviews the only other prescription drug program available across-the-board in Mississippi, and this is under CHAMPUS. The association already has computer files on the 704 licensed pharmacies in the state and on practicing pharmacists. A wealth

of scientific data is available from pharmacists' claims, and patient identification flags utilization accurately and effectively. This is not to infer or suggest in any manner that the Medicaid drug program is not comprehensively and effectively reviewed. Further, it should be appreciated that difficulties implicit in a welfare-oriented drug program substantially exceed those encountered under CHAMPUS.

The association's peer review program is a magnificent team effort among physicians, extending beyond the committee, the Board of Trustees, the officers, and staff. Without wide support and appreciation for the worthy goals we seek in care quality, there would be no such advanced state of development. But the committee is looking beyond this present state of development.

We recognize that we have only a *retrospective* tool for care quality review, an after-the-fact examination. It is priceless, to be sure, but we—as objective investigators—raise a question, asking if this is enough. Should we not also strive to develop *prospective* review under physician-managed, private practice aegis?

Should we not devise and made available a consultative service at the time of a patient's admission to the hospital? Should we not act before the fact on potential under- and overutilization? Should we not do something about medical care financing mechanisms which willingly pay the bill for a "standard" hospital stay without considering any other aspect of the care?

Many share the sincere belief that our present concepts of peer review must and will be revamped and revised to answer these challenging questions. We subscribe to this tenet not as a defensive measure, awed and cowering before the might and majesty of third party money. We believe that the urgent need to realize maximum efficiency from present and future available professional manpower and medical facilities for improving care quality and optimum utilization literally demands this course of action. But it should and must be a course developed and chosen by practicing physicians whose quest for these good and meritorious ends reflects their own self-imposed ethics and dedication.

Medicine was once only an art. Then it became a science and an art. Today it is a microcosm of art, science, socioeconomics, philosophy, and demography. And probably much more.

From 1847 when our AMA was born at Philadelphia to 1971 and a new commitment to care quality in Mississippi is a long way. The purpose is the same—we are merely improving the method. ★★★

Post Office Box 27 (38947)

The Mississippi Experimental Medical Care Review Organization project is assisted by U. S. Public Health Service Grant 1 R18 HS-00798-01 SRC under the National Center for Health Services Research and Development.

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CART BEFORE THE HORSE

A fellow said the other day that they have a "wonder drug" up at the Mayo Clinic, so new they haven't even got a disease for it yet.

Medical Care Foundations: Private Practice's Answer

ROWLAND B. KENNEDY
Jackson, Mississippi

THE MEDICAL CARE FOUNDATION is the most popular, widely discussed innovation in private health care delivery in the United States. It is a positive assertion of medical leadership and an affirmative response to support of free choice. Many define a foundation as a delivery system unto itself. Most see it as an efficient management system. A few regard it as merely a perpetuation of the cottage industry nonsystem which they fancy to exist. The foundation is solidly established, and it works.

How well does the medical care foundation work?

—*Fine for us,* say 4 million patients in 20-odd states.

—*The voice of the private sector,* respond 40,000 physicians.

—*Highly satisfactory,* reply a dozen major insurance carriers and Blue plans.

—*We count on it,* asserts corporate management.

—*We're happy with it,* says labor.

And government, the biggest purchaser of health care, is reposing its trust and confidence in the medical care foundation. So from about every viewpoint, the foundation—a creature of the privately practicing profession and their respective societies—may just well be the economic and quality measurement phenomenon of the 20th century in health care delivery.

In the final analysis, the MCF is a close-tolerance balance of a fair, impartial means of delivering care in the traditional sense. The state medical association's Board of Trustees says that foundations "do not retail medical care but rather, in the words of the stock exchange, assure an orderly market for fair trading." The immediate past president of the association, Dr. Paul B. Brumby of Lexington, calls the care foundation "an honest broker."

So reduced to the least common denominator, medical care foundations have become the most widely accepted vehicles working for good health in the context of private practice. They are creations of the medical profession offering more visibility to responsible medical leadership than any socioeconomic and quality control development in a generation.

State medical associations and county medical societies sponsoring medical care foundations stretch the length and breadth of the nation. The Mississippi Foundation for Medical Care is among the newest, and by reason of a unique background of leadership exercised by physicians, promises to be one of the best.

Born in California in 1954, the medical care foundation came into being as a matter of necessity. In Stockton, Calif., the county medical society was confronted with the problem of who

We do not believe that solo practice and fee for service are as dead as a dodo, said Dr. Donald C. Harrington, founder of the San Joaquin (Calif.) Foundation for Medical Care. From that historic day in 1954, the foundation concept has gained momentum and now is sweeping the 55 state and territorial medical associations.

This examination of the medical care foundation traces its genesis, development, growth, and direction as a creature of the medical profession, a buffer between physician and third party, an advocate of the patient, and an instrument of private practice.

President, Mississippi Foundation for Medical Care.
Executive Secretary, Mississippi State Medical Association.

ON BECOMING A FOUNDATION MEMBER

As this special issue of the JOURNAL examines medical care foundations and traces the history and development of the new Mississippi foundation, most physician readers will want to know how to apply for participating membership. The abbreviated application form, needing only a check mark and a signature, is or soon will be in the hands of every member of the association.

The application is printed on a computer card and was enclosed with the Oct. 15, 1971, billing for dues. The application may be returned with dues payment in the postage-paid envelope which was also included.

The Board of Directors of the Mississippi Foundation for Medical Care has voted unanimously to assess no dues for charter participating members for 1971-72.

Eligibility for foundation membership is limited to members of the Mississippi State Medical Association and to physicians who are eligible for membership in the association but who are not, at the time of application for foundation membership, actually on the rolls of the association.

Election to participating membership in the foundation is by the Board of Directors. The by-laws of the foundation are published for the information of all following this paper.

would deliver medical care: The private practicing community or a closed panel, prepaid group. As far as the private practitioners were concerned, the answer was obvious, and the society acted.

Dr. Donald C. Harrington, a Stockton obstetrician-gynecologist, conceived the idea of a subsidiary corporation which could do those things for physicians, patients, and financing mechanisms which a medical society could not do. He found that the medical society might not make certain contracts, could not make certain commitments, and could not legally posture itself within the confines of the nonprofit medical society corporation to do everything which was needed and desired.

Then there were questions about antitrust violations and restraint of trade laws. Here again, the foundation as a subsidiary corporation, organized for community service and not for profit, was the answer. So the San Joaquin Foundation for Medical Care was born, destined to become the model and granddaddy of them all.

With the diverse purposes, courses, and directions taken by subsequently developed foundations, some say that it has a clumsy name, is an unwieldy legal person, and a *non sequitur* defying rational definition.

But this is really not so, and for many reasons. First of all, the MCF is a workable, acceptable, responsible device. Second, it is, in the context of that legal euphemism, for the public interest, most of all as the advocate of the patient. Finally, it is a creation of the private practice community, dedicated to free choice, quality care, and medical leadership.

The Mississippi Foundation for Medical Care is a prime example of these tenets, because it is committed to these principles:

—The foundation conducts peer review—the quality control function in care delivery—generally considered the heart of the foundation concept. And this means that only physicians may oversee the work of other physicians, as this should be.

—The foundation provides for the medical profession's assuming leadership over and direct responsibility for medical care delivery.

—The foundation is the most responsible and knowledgeable mechanism for claims processing and payment for medical services rendered, and this is a function integral to the review and responsibility concepts and functions.

—The foundation sponsors and conducts utilization review, assuring that expensive and sometimes scarce facilities are optimally employed at maximum efficiency.

It is entirely possible that the Mississippi Foundation for Medical Care would have become a reality without its pioneering predecessors. In a sense, the state medical association has subscribed to the foundation concept for a decade and a half. In 1956 when the Congress enacted the original military Medicare, now the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the association made the decision to qualify as the fiscal administrator.

Mississippi medical leadership of that time and day correctly postulated that physicians and their state medical association are best qualified to oversee the professional practices of their colleagues. They understood, as did so few in that day, that physicians are also qualified to understand best the values placed upon professional services. And, of equal importance, to recognize that tiny minority of instances where services may be overvalued.

CHAMPUS in Mississippi has been the most successful and satisfactory of all government-sponsored medical care programs:

—It has proven the quality of medical leadership in the administration of care delivery.

—It has assured the patient of receiving all the medical care he needs.

—It has been a just and equitable two-way street economically, fair to third party, patient, and physician, developing into a true usual, customary, and reasonable fee program.

—It has pioneered physician review of services and claims through the CHAMPUS Review Committee.

Against this background, it was only logical that the successes of the West Coast foundations and their proliferation eastward kindled a new awareness of their value among the several state medical associations. Foundations were established in Florida and Georgia. In the midwest, Iowa, Illinois, Minnesota, and Missouri associations created their own care foundations.

Farther west were Arizona, Colorado, New Mexico, and Oregon. In the east, the giant societies in New York, Ohio, and Pennsylvania brought their foundations into being. Out in the Pacific, the westernmost state, Hawaii, created a model. The Mississippi Foundation for Medical Care was authorized by the House of Delegates at the 103rd Annual Session and is being followed by Tennessee and Kentucky. Almost as many others are on the medical association drawing boards.

. . . solo practice and fee for service are not dead as a dodo.

The American Medical Association estimates that by mid-1972, as many as 40 to 45 state medical associations shall have established medical care foundations and that more than half will be fully operational.

If all of this were not sufficient to signal the wave of the future, consider pending health legislation before the 92nd Congress and the findings of congressional committees in the last session. The successes of the western foundations made the point with the solons: They are in the serious business of delivering quality medical care at a predictable cost. It is only logical that substantial reliance is placed in foundation care plan administration, and this is reflected in virtually every health care financing bill.

Although foundations vary in interests and major purposes, common threads of similarity are woven into all, and the Mississippi Foundation for Medical Care is kindred in these goals:

. . . the foundation assures an orderly market for fair trading.

—It seeks to promote, develop, and encourage the distribution of medical services at a cost which is just and equitable to patient and physician.

—It zealously safeguards care quality with physician—and physician only—peer review.

—It seeks to preserve freedom of choice of physician and medical care facility.

—It jealously guards, preserves, and fosters the time-honored, traditional physician-patient relationship.

—It seeks to protect the public health.

It works cooperatively with private insurance, voluntary prepayment, and tax-supported medical care plans to provide for periodic and realistic budgeting of just and proper costs.

But before getting down to a precise description of exactly what the Mississippi Foundation for Medical Care is, let it be clearly understood what it is not:

—It is not something which can or will deny nonmembers normal practice freedoms and professional prerogatives.

—It does not and cannot affect the membership status or nonmembership status of any physician in his local society, state association, AMA, or specialty society.

—It does not and cannot affect the privileges conferred by licensure upon a physician.

—It is not an insurance, prepayment, or government care plan financing mechanism. As a

foundation, it doesn't have a dime to its name except for at-cost income derived from participating care plans to support its activities. This is from sources billed at cost for services actually rendered.

—And it is not the answer to every problem facing the health care delivery system today, but it is a system which works in the hands of the medical profession.

What the Mississippi Foundation for Medical Care is should be attractive to physicians, as it obviously was at the 103rd Annual Session when the proposal was approved by the House of Delegates. It is, first of all, a creature of Mississippi medicine, of physicians' own thinking, their own rendering of service, their own dedication, and their affirmative declaration to judgments worthy of acceptance.

Summing up best of all the case for the medical care foundation, Dr. James L. Royals of Jackson, 1969-70 president of the state association, said that "the health delivery system is on trial."

"I do not claim perfection for our care delivery system," Dr. Royals declared in his presidential address. Confessing his discontent with many changes we are seeing in the world today, he pointed out with frankness that "we must recognize that we are living in a dynamic time, a time of rapid and dramatic change, of new and varied social forces, of miraculous technology, and of troubled political balance in a volatile world."

But, Dr. Royals emphasized, the change of which we speak in medicine may not be so dramatic after all, for we may be awakening to something we have largely ignored, the change of medicine's own making, something which may already be here.

. . . provides for medical leadership and responsibility for care delivery.

He made it clear that the name of the change is the foundation for medical care, a device of medicine's making, alive and well, serving nearly a fifth of the practicing profession and millions of patients in almost half of the states. He placed greatest emphasis on physician-sponsored, physician-conducted review of care quality, exercise of leadership by the profession in delivery systems, and "the making of responsible judgments worthy of acceptance."

The Mississippi Foundation for Medical Care is a logical extension of the state medical association which would not, however, be possible without the subsidiary foundation corporation. It is a voluntary means with which to preserve private practice. Dr. Harrington, the moving force behind the San Joaquin Foundation, had this to say:

. . . to preserve freedom of choice of physician and medical care facility.

"The foundation is patient oriented. We believe deeply that what provides the best medical care for the patient will, in the long run, be best for the medical profession. We do not believe that solo practice of medicine and fee for service concept are 'dead as a dodo.' "

The foundation is obviously self-disciplined in its functions but really no more so than any ethical physician who disciplines himself and subscribes to the *Principles of Medical Ethics*. In practice, medical care foundations have shown themselves fully capable of making worthy and responsible judgments, and these judgments are accepted by care consumers and financing mechanisms as reliable.

Some ask, why have a medical care foundation when we in Mississippi already have peer review, medical care plan administration, trained and experienced staff, data processing, and office facilities? Why a foundation when we have already developed a working, usual, customary, and reasonable fee program in CHAMPUS? Why set up another organization to join?

As suggested in the genesis of the San Joaquin Foundation, the answer is simple and direct: A medical care foundation can do those things which a medical association as such ordinarily does not do and in some instances, may not do.

The foundation charter as a nonprofit corporation permits it to conclude contracts with insurance and prepayment organizations, with management, with employee representatives, and with government financing mechanisms—all within a mutually acceptable framework. Since foundation membership is voluntary, then it represents the will of a majority who literally own and operate it.

Second, the foundation is a highly acceptable care delivery mechanism and could well be the only such acceptable mechanism under medical sponsorship in future public care programs. For example, most of 50-plus bills for national

health insurance pending in the Congress have three things in common:

—Each would abolish Medicare.

—Each requires peer review.

—Each could be administered by a medical care foundation.

Third, the foundation's unique legal personality does not violate antitrust and restraint of trade laws. And fourth, it stands as a buffer between the private physician and the third party as the advocate of the patient.

Dr. Harrington, asserting that the foundation is not an insurance company, calls it a catalyst. What might be added is that the foundation is a medical catalyst.

The Mississippi foundation is a wholly-owned, nonprofit, voluntary corporation controlled by the Mississippi State Medical Association. It is governed by a Board of Directors, not less than nine nor more than 12 in number. As is done in the medical association, no director may serve more than three consecutive terms of three years each. The board chairman is the real and acknowledged head of the foundation, and his fellow physician-officers are the vice chairman and secretary-treasurer.

The foundation's executive staff consists of a president and a vice president-comptroller. The directors may appoint such other subordinate officers as necessity may require. Provision is made in the by-laws for committees which are named by the Board of Directors.

As is true with all other medical care foundations, the Mississippi organization has two classifications of membership, administrative and participating.

Administrative members are the Trustees of the state medical association, and in them are vested two important authorities: The Board of Trustees appoints the foundation's Board of Directors, assuring that the will of the medical association extends into every organizational and operational aspect of the foundation. The Trustees may also amend the foundation's by-laws, another measure of physician control.

. . . a buffer between physician and third party, as the advocate of the patient.

Participating members are those physicians, either members of the state medical association or who are fully qualified for membership, who voluntarily apply for membership to avail themselves of foundation benefits. For 1971-72, no dues are charged for participating membership.

The Mississippi Foundation for Medical Care will conduct an annual membership meeting at which all participating members may vote. A full stewardship accounting will be made to the foundation membership.

So foundation membership, while offering many obvious benefits, gives the private practitioner a voice in his own medically controlled review and financing mechanism and assures him representation in payment of just and equitable fees. In some areas of the nation, participating members of medical care foundations are compensated under the usual, customary, and reasonable fee concept while nonmember physicians are paid on an indemnity basis by the same insurance companies and care plans.

. . . gives the private practitioner a voice in review and financing mechanisms.

In a splendid research paper, "Foundations for Medical Care," published by the Blue Cross Association, Carolynn Steinwald classifies foundations under three models: California, Hennepin County (Minnesota), and Missouri.

The working prototype of the California model is San Joaquin, offering a full range of services. Under medical society sponsorship and control, it conducts care quality review, examines utilization of medical services and facilities, processes and pays claims, and designs coverage for underwriters and groups.

There are 18 foundations serving 32 counties in California. Fourteen of these foundations serve 1,058 groups totalling 620,000 policy owners covered by a dozen of the better health insurance companies.

Ten foundations in California represent Blue Shield and Blue Cross, handling 55 groups chiefly under Blue Cross of Southern California at Los Angeles and Hospital Service of California at Oakland. California Blue Shield, formerly the California Physicians Service, is an activity of the California Medical Association operating statewide.

The California foundations deal primarily with

employer groups. They cover state employees, and all 18 foundations have contracts to cover county employees. Half of the foundations have contracts to cover city employees. They are strong in school health services programs, ranging from public school districts to universities.

The San Joaquin Foundation administers Medicare, Medi-Cal (Medicaid), CHAMPUS, and services groups under commercial insurance and the Blue plans. The 18 foundations process, review, and pay about 70,000 claims per month for commercial insurance and Blue plan coverage and about 370,000 per month for public care programs, a total of 440,000 claims per month. In the San Joaquin example, 98 per cent of physicians in private practice are participating members.

In addition to boards of directors and executive officers, the California foundations have two key committees: The Quality and Cost Review Committee conducting peer review and the Foundation Reimbursement Committee. The latter oversees contract agreements and professional compensation based on dollar amounts applied to the California Relative Value Study of 1969-70. Renegotiation of these contracts takes costs of living and general price levels into consideration, permitting periodic, timely, and realistic adjustment of fee levels. Claims processing includes administrative review, reviewing physicians, and the full review committee.

The vast majority of claims are processed and paid at the administrative level. All review for care quality is conducted by physicians as are questions of overcharge and excessive utilization. The review committee sees only about 1 per cent

. . . successes of West Coast foundations kindled a new awareness of their value.

of the claims. Some California foundations are serving dentists, optometrists, clinical psychologists and physical therapists. All of the foundations review inpatient services in hospitals, extended care facilities, and nursing homes.

Payments to California foundations for their services are made by insurance companies and prepayment plans on a premium-per cent formula. Most charge 4 to 5 per cent of the first $50,000 in premiums for a group and 2.5 to 3.5 per cent above the base amount or premiums in excess of $50,000.

The Hennepin County model, the Steinwald report reveals, differs in operational aspects from the California model but has the same purposes and goals. The differences are in three areas: Application of minimum coverage standards, foundation relationship with insurance carriers, and peer review.

. . . by mid-1972, as many as 40 state associations shall have foundations.

The Foundation for Health Care Evaluation of Hennepin County does not make minimum standards of coverage a prerequisite for its contracts. Made as a concession to third parties in securing support, the foundation supplies carriers with lists of recommended benefits.

The foundation says it chose this course "to avoid the difficulties encountered by other foundations which have designated insurance plans that are more comprehensive than the public or industry is willing to pay for."

Second, the Hennepin Foundation does not process claims for third parties, believing that the insurance companies are best qualified by experience, facilities, and personnel to undertake this task.

This demonstrates the validity of an observation made by the Mississippi State Medical Association's Board of Trustees in its report on care foundations to the House of Delegates in May 1971:

"The move to a medical care foundation for a majority of state (or other) medical associations is difficult, extensive, and costly. Most associations are without experience and administrative mechanisms for claims processing, payment, data processing, and related services. We have such capabilities. . . ."

The Hennepin Foundation furnishes carriers with "norms" and fee guidelines. The lists contain parameters of acceptable medical procedures (from the Michigan Hospital Utilization Review Manual) and are to be used to screen out claims not meeting the criteria. Thus, the peer review function is performed under foundation guides by insurance carriers for most claims with only problem cases going into the foundation's peer review committee.

The Missouri model is essentially a peer review organization. A joint sponsorship by the medical and osteopathic association stands be-

hind the Health Care Foundation of Missouri, and its principal concern is monitoring of Medicare and Medicaid. The foundation does not sponsor insurance or Blue plan coverage, sets no minimum coverage standards for benefit services, and makes no determination as to fees. Its membership consists of 4,000 MDs and 1,000 osteopaths, and the two statewide professional organizations pay the costs of foundation operations, since no decision has been made on a formula to charge carriers for foundation services.

Five district review panels serve the Missouri foundation, each consisting of seven members. Five are MDs representing surgery, family practice, obstetrics and gynecology, and one other specialty optional to the region served. Two members are osteopaths. Utilization guides applied by the district panels are those of the Hennepin Foundation or the Michigan manual.

As conceived in studies by the Board of Trustees and Council on Medical Service in Mississippi, our foundation more nearly fits into the California pattern with minor variations. The association has long endorsed physician management of medical care plan administration, has affirmed the utter necessity of peer review in care quality evaluation, and has created a means of doing it all.

The medical care foundation in Mississippi has the capacity to put it all together as well as the capability, personnel, experience, data processing, and facilities to render full foundation services. And there can be no doubt that association leadership and the House of Delegates understand the realities of the day and the need to deal responsibly, realistically, and honorably with third parties and, in Dr. Harrington's words, the institutional purchasers of medical care. So the matter can be distilled down to care quality and effective representation of patient and physician to third parties and institutional purchasers of care, be they industry, government, or employee groups.

. . . the Mississippi foundation has the capacity to put it all together.

Here, the medical care foundation fills its unique role of keeping a critical eye on care quality while standing as a buffer between the physician and third party as the advocate of the patient. Dr. Harrington makes the point forcefully:

"It may be pleasant to daydream about rolling history back to the time—if it ever existed—when the only elements in the medical care picture were the physician and the patient. It may be fashionable in some quarters to refer to the third party in medical care as if it were a social disease.

. . . change of medicine's own making, something which we may already have.

"I believe it is safe to say that institutional purchasers of medical care are here to stay and that they will grow in size and importance rather than wither away in the foreseeable future.

"The question for the future—the basic challenge for all parties—is this: Can these diverse interests find a satisfactory way of life, with the patient realizing the benefits of modern medical care; the physician achieving the professional, psychological, social, and financial rewards related to his contribution to the community; the institutional purchaser having increasing assurance that needed medical care funds are well spent; and the organized medical profession having the increased satisfaction that standards of medical care are being progressively improved?"

The well-conceived, properly organized, and conscientiously administered medical care foundation could just be the *only* answer to this challenge of tomorrow. ★★★

735 Riverside Drive (39216)

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By-Laws of the Mississippi Foundation for Medical Care

Article I
NAME OF THE CORPORATION

The name and title of this corporation shall be the Mississippi Foundation for Medical Care, Inc.

Article II
PURPOSE OF THE CORPORATION

The Mississippi Foundation for Medical Care, Inc., is a corporation not for profit organized under the laws of the State of Mississippi for the following purposes: To promote, develop, encourage, and assist in the distribution of quality medical care to the general public in Mississippi at a reasonable cost to the patient and provider and in accordance with proper medical and ethical standards; to foster and preserve the time-honored patient-physician relationship and the exercise of free choice of physician and medical care facility by the patient; to study and promote improved methods and facilities for health care and the improvement and protection of the public health; to study, implement, and assist in the administration of means of financing health care, acting in conjunction with medical societies or associations, patients, hospitals, nursing homes, and other health care facilities, and the insurance industry, hospital service corporations, voluntary prepayment plans, various branches of government, representatives of management and labor, and other interested persons, organizations, and corporations; to promote the art and science of medicine and to foster medical and professional education; and to disseminate information to the general public concerning medical science and quality, ethical, medical care; to receive and acquire by gift, grant, purchase, devise, bequest, or otherwise, as may be lawful, money and real and personal property of any kind and to hold, accumulate, invest, or dispose of such property or the income derived therefrom for the furtherance of the above stated purposes; to do and engage in any and all lawful enterprises and activities which may be incidental or reasonably necessary to any of the foregoing purposes, and to have and to exercise all other powers and authorities now and hereinafter conferred upon nonprofit corporations under the laws of the State of Mississippi.

Article III
EXECUTIVE OR CENTRAL OFFICES

The President and Chief Executive Officer shall maintain in the City of Jackson suitable offices for the discharge of his duties and for conducting the administrative affairs of the Foundation.

Article IV
MEMBERSHIP

Section 1. *Classification.* There shall be two classes of membership in the Foundation: Administrative membership and Participating membership.

Section 2. *Administrative Members.* The Administrative members of the Foundation shall be the members of the Board of Trustees of the Mississippi State Medical Association, and they shall also be Participating members of the Foundation.

Section 3. *Participating Members.* Any physician licensed to practice medicine in the State of Mississippi who is a member of the Mississippi State Medical Association or who is qualified and eligible for membership in the Mississippi State Medical Association but who is not actually a member thereof shall be eligible to apply for Participating membership in the Foundation. Election to Participating membership in the Foundation shall be granted by the Board of Directors to any such qualified physician upon his making proper application therefor, and such membership shall be renewable annually, contingent upon qualification and re-application, as may be determined by the Board of Directors. Dues and assessments charged Participating members shall be established by the Board of Directors, subject to ratification and approval by the annual general membership meeting.

Section 4. *Benefits of Membership.* Benefits and privileges of membership in the Foundation shall include but not be limited to participation in all Foundation programs as set out in Article II above and the right to vote and hold office in the Foundation except as otherwise may be restricted or prohibited by these By-Laws. Evidence of membership shall be issued to each Administrative and Participating member by the Secretary-Treasurer annually. Membership in the Foundation is nontransferrable, either by voluntary or involuntary act or by operation of law.

Section 5. *Discipline.* The Board of Directors shall provide for fair and impartial hearing on complaints brought in writing against any member of the Foundation with due process in the guarantee of his rights and privileges. Members found to be in violation of the *Principles of Medical Ethics of the American Medical Association,* these By-Laws, and/or the laws of the State of Mississippi or the United States shall be subject to censure, suspension, or expulsion from membership. Any member of the Foundation expelled from membership shall not be eligible to re-apply for a period of one year.

Article V
BOARD OF DIRECTORS AND OFFICERS

Section 1. *Board of Directors.* The corporate Board of Directors of the Mississippi Foundation for Medical Care, Inc., shall consist of 12 members who shall be elected by the Administrative members for terms of three years each and so arranged that one-third of the Board of Directors is elected annually. No director shall serve more than three consecutive terms or a total of not more than nine years. A director shall be a Participating member of the Foundation, and at least nine members of the Board of Directors shall be Trustees of the Mississippi State Medical Association.

Section 2. *Election of Directors.* Directors of the

Foundation shall be elected by the Administrative members at the December meeting each year.

Section 3. *Terms of Directors.* The term of office of a director of the Foundation shall begin on January 1 and continue for three consecutive calendar years, terminating on December 31 of the third year. A director shall be eligible to serve no more than three consecutive terms.

Section 4. *Officers of the Board.* The officers of the Board of Directors and the real and acknowledged leaders of the Foundation shall consist of a Chairman, a Vice Chairman, and a Secretary-Treasurer. They shall be elected for terms of one year each by majority vote of the Board of Directors.

Section 5. *Officer-Executives.* The Board of Directors shall elect a chief executive officer of the Foundation who shall be President, a Vice President and Comptroller, and such other subordinate officer-executives as are deemed necessary on an annual basis, none of whom need be a physician or Participating member of the Foundation. Compensation of officer-executives and reimbursement for expenses actually incurred in performance of official, authorized duties shall be fixed and arranged by the Board of Directors.

Section 6. *Duties of Directors.* The affairs, business, and properties of the Foundation shall be under the exclusive management of the Board of Directors which is the corporate governing body. In the exercise of authorities herein conferred, the Board of Directors is empowered to delegate management of corporate affairs, implementation of policies, and such other activities as may be deemed appropriate and in furtherance of the Foundation's purposes to the President who shall be responsible to the Board of Directors. Members of the Board shall be faithful and diligent in the discharge of their duties, in attendance upon meetings, and in carrying out the purposes of the Foundation.

Section 7. *Duties of Officers.* The President and Chief Executive Officer shall be elected or appointed by the Board of Directors on an annual basis and be responsible thereto. He need not be a physician or Participating member of the Foundation. He shall attend all meetings of the Board of Directors and shall be responsible for managing the administrative affairs of the Foundation, reporting to the Board. He shall serve at all times to perform such other duties as may be assigned to him by the Board of Directors as may be deemed beneficial to the Foundation. He shall be custodian of all books, records, and papers belonging to the Foundation, and he shall keep careful and detailed accounts of such funds delivered into his hands in the name of the Foundation, promptly placing these under the supervision of the Secretary-Treasurer, using such depositories as are designated for this purpose by the Board of Directors. He shall conduct the official correspondence of the Foundation, supervise and manage under Board policies programs of the Foundation, and render such reports of his stewardship as may be required from time to time by the Board. He shall give bond for the faithful performance of duties at the expense of the Foundation. He shall issue evidence of membership to those elected by the Board of Directors upon direction by the Secretary-Treasurer, and he shall publish and disseminate such bulletins, newsletters, and miscellaneous publications as may be prescribed and authorized by the Board. He shall maintain official rolls of membership, and he shall employ such assistants and staff as the Board may authorize. The Vice President and Comptroller shall assist the President and Chief Executive Officer and to him shall be assigned the work of accounting and office management under the direction of the President. Duties of additional subordinate officer-executives shall be prescribed by the Board of Directors upon authorization and establishment of such positions.

Section 8. *Meetings of the Board.* The Board of Directors shall meet not less than twice annually and at such other times as necessity may require upon call by the Chairman or upon petition by one-third of the membership of the Board. The Chairman shall preside at meetings, and in his absence, the Vice Chairman shall preside. Unless notice of meetings is waived, notice shall be sent by first class mail to each Director to his post office address of record not later than 10 days prior to the meeting called. The place of a meeting shall be chosen by the Chairman or, in fixing the time of a future meeting, by majority vote of the Board. The Secretary-Treasurer shall prepare, publish, and distribute minutes of all meetings, provided, however, that he may delegate this duty to the President who shall be responsible therefor. Meetings may be held at any time without notice if all Directors are present or if at any time prior to or after the meeting those present waive notice of the meeting in writing, filing same with the Secretary-Treasurer. A quorum of members of the Board of Directors must consist of a majority for the transaction of business. Voting by proxy or mail is expressly prohibited.

Section 9. *Committees of the Board.* The Board of Directors is empowered to create such committees as may be necessary for the efficient function of the Foundation and shall prescribe the duties of committees so created and appointed, provided, however, that the committee concerned with finance shall consist only of members of the Board of Directors. Members of committees shall be appointed to serve no more than one year or at the pleasure of the Board of Directors. The Board shall appoint the chairmen of all committees, and members of such committees shall be Participating members of the Foundation, provided, however, consultants to committees, who may be appointed to provide special expertise and who need not be Participating members of the Foundation, shall serve without the right to vote. A committee of the Board shall consist of not less than three members.

Section 10. *Executive Committee of the Board.* The Executive Committee of the Board of Directors shall consist of the Chairman, Vice Chairman, and Secretary-Treasurer and shall have and may exercise any and all powers and authorities of the Board except as restricted by the Board in the delegation of powers and authorities and as by law for nonprofit corporations. The acts of the Executive Committee shall be subject to ratification by the Board of Directors.

Section 11. *Rules and Regulations.* The Board of Directors may adopt at its pleasure such rules and regulations which are not inconsistent with the Charter of Incorporation and these By-Laws as it deems desirable and necessary for the conduct of its activities and the furtherance of the purposes of the Foundation.

Article VI
GENERAL MEETINGS

Section 1. *Annual Membership Meeting.* The annual membership meeting of the Administrative and Participating members shall be conducted during the annual session of the Mississippi State Medical Association at the site of said annual session. Due call for and notice of the annual membership meeting shall be published in the *Journal of the Mississippi State Medical Association* not later than 30 days prior to the annual session and membership meeting, provided, however, that written notice shall be sent by first class mail to Participating members of the Foundation who are not members of the Mississippi State Medical Association 30 days prior to the membership meeting.

Section 2. *Special Membership Meeting.* A special membership meeting of the Administrative and Participating members of the Foundation may be called by majority vote of the Board of Directors. Notice of such special meeting shall be given in the manner prescribed for the annual membership meeting. Business before a special membership meeting shall be restricted to matters brought by the Board of Directors.

Section 3. *Quorum.* A majority of the Administrative

members and 50 Participating members shall constitute a quorum for the transaction of business at the annual membership meeting or at a special membership meeting.

Section 4. *Proxy*. Voting by proxy at the annual membership meeting or at a special membership meeting is expressly prohibited.

Section 5. *Registration and Record of Attendance*. The Secretary-Treasurer shall provide for registration of Administrative and Participating members at the annual membership meeting or at special membership meetings and shall prepare and maintain a record thereof, provided, however, that he may delegate this duty to the President who shall be responsible therefor.

Article VII
MISCELLANEOUS PROVISIONS

Section 1. *Seal*. The Board of Directors shall adopt a corporate seal and have the power to break, change, or renew the same at its pleasure.

Section 2. *Fiscal Year*. The fiscal year of the Mississippi Foundation for Medical Care, Inc., shall commence on January 1 and end on December 31 following.

Section 3. *Indemnification*. The Foundation shall indemnify its directors and officer-executives and may, by resolution of the Board of Directors, purchase liability and/or accidental death and dismemberment insurance on their behalf as a measure of protection for the corporation.

Section 4. *Amendments to By-Laws*. These By- Laws may be amended, altered, or repealed and new By-Laws adopted (1) by majority vote of the Administrative members or (2) by majority vote of the Participating members at the annual membership meeting or at a special membership meeting, provided, however, such proposed amendment is placed on the agenda for such special meeting or (3) by two-thirds vote of the Board of Directors, provided, however, that the Board of Directors shall not have the right to repeal any amendment hereto previously adopted by the Administrative members or by the Participating members unless such amending or repealing authority is expressly delegated to the Board of Directors in the resolution effecting such amendment, and provided further, however, that notice of any amendment to or repeal of these By-laws shall be given to the body empowered to and proposing to effect such amendment not less than 10 days prior to the meeting at which action on said amendment or repeal is proposed.

DEFINITION

Public speaking is the art of expressing a two-minute idea with a two-hour vocabulary.



The President Speaking

'Keeping the Faith'

ARTHUR E. BROWN, M.D.
Columbus, Mississippi

EVERY DAY MILLIONS of American citizens walk into doctors' offices in the hope that the doctor they have selected will have the knowledge and skill necessary to help them regain their health. Most of them have faith and belief in the ability of the doctors to cure. We must help them keep that faith.

We are being threatened now with some form of national health insurance. We are being accused of rendering a poor quality of care at too high a cost to the people.

Your state medical association has taken steps which should aid us in whatever type of legislation is passed. Your Mississippi Foundation for Medical Care has been formally organized, incorporated, and has elected officers who are hard at work. The decision to proceed with this organization was made after many meetings and countless hours of study.

It is apparent that within one or two years some form of national legislation will be passed regarding health care. But it will be in the form of some compulsory plan. By contrast, in the foundation your participation is voluntary. Each individual is free to join or not according to his own decision. We have been approved for a grant to finance an experimental program called EMCROW. A full explanation appears in this issue of the *Journal*.

In the meantime, please attend your local society meetings as many of these are having speakers to explain how these programs work. The program is being set up for one purpose only. It is to see that we furnish a high quality of medical care at a reasonable cost in a physician-oriented, physician-managed program. If we do this, we will be able to keep that faith that has been placed in us. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 11

NOVEMBER 1971

EDITORIALS

Put It All Together for Quality Care by Private Practice

I

AUGUST 25, according to Dr. J. T. Davis of Corinth, chairman of the association's Board of Trustees, is destined to become as significant to Mississippi physicians as Dec. 15. It was on the latter date in 1856 that the state medical association was organized and founded at Jackson. The Mississippi Foundation for Medical Care was formally organized as the association's wholly owned, nonprofit subsidiary on Aug. 25, 1971.

Dr. Davis could well designate 1971 as a benchmark year, too, for the succession of events in development of peer review, the grant of $369,000 to fund the development of physician-sponsored review, and organization of the foundation could just be the most important in 115 years of Mississippi State Medical Association history. All of this is an affirmative, positive move toward medical leadership in and responsibility for quality health care delivery.

Over the past two decades, voluntary prepayment and health insurance have grown and proliferated. Medicare entered the scene in 1965, and the old vendor medical programs under the welfare titles gave way to Medicaid. An endless host of one-shot care plans surfaced through OEO, community action projects, prepaid group practice, and varied, specialized programs at nearly every level of government. We would not be remiss to tag it the Era of the Third Party.

II

Being the realists that we all are, we recognize both the advantages and vexations involved in somebody other than the patient paying the bill, or most usually, part of it. The privately practicing profession has supported voluntary prepayment and health insurance. Physicians have not totally opposed government's responsibly playing such a role. But objection has been appropriately raised to growing third party bureaucracy, the sea of paperwork, and arbitrary determinations of how much care shall be rendered and how much will be paid.

The leadership of the Mississippi State Medical Association is not so naive as to believe that the positive actions of this year are an overnight panacea to these vexations and frustrations experienced by practicing physicians. The Mississippi Foundation for Medical Care cannot transform medical care financing problems into light and sweet sunshine next week or even next year. The important thing to appreciate is that this is a beginning.

The highly successful, pioneering San Joaquin (Calif.) Foundation for Medical Care has been

operational for 17 years. Our CHAMPUS program, generally considered a model of tax-supported, physician-managed delivery vehicles, is in its 14th year. But by no means is the association leadership resigned to waiting a decade and half to see the same results from the foundation, either, because what is past is prologue, and the association is pledged to build upon experience. All of this is to caution against expecting miracles but to work as if we intended to produce one tomorrow.

III

While physician-conducted review of care quality is the heart of the foundation, it does even more in serving patient, physician, third party, and others in the care picture. It strives for better health care coverage in insurance and voluntary prepayment. At all times, its purpose is to be realistic about health care budgeting while it simultaneously works for optimum benefits from expenditure of the health care dollar.

Ongoing foundations, especially the California models, brook no nonsense in seeking this balance of fairness. Their purpose is delivery of quality care by privately practicing physicians. In the pursuit of this goal, physicians manage the enterprise with the serious determination which their serious purpose demands.

There are built-in safeguards in the foundation concept, a sort of fail-safe mechanism. Either the foundation does an acceptable job of maintaining this fair and equitable balance or it falls flat on its face. The possibilities which are sure pathways to early demise are three:

—The financing mechanism doesn't follow the ground rules, so the physicians bow out.

—The physicians vary from the ground rules, and the third party quits.

—The foundation abdicates its responsibilities, and the physicians and third party kiss it goodbye.

And in any event of the foregoing eventualities, the patient is the loser, the worst consequence of all, which a demanding society will simply not permit.

Each corner of the quadrangle must be securely trussed with integrity, strength of purpose, and serious dedication, because structural failure at any of the four corners is a fatal stress upon the other three.

IV

Most physicians recognize the opportunities implicit in making their foundation work. They understand and appreciate the value of physician-conducted peer review. They are totally committed to improving the quality of medical care. They earnestly desire to see maximum efficiency in utilization of scarce professional manpower and expensive medical facilities. And they are acutely conscious of the urgent need to realize optimum benefit from expenditure of the health care dollar.

So this is not, as Plato wrote, kidding democracy, "dispensing equality to equals and unequals alike." Conversely, the key is equitability and advocacy of the patient's well-being, along with—quite candidly—an enlightened self-interest among all concerned.

Within a matter of days, brief forms for participating membership applications in the Mississippi Foundation for Medical Care will be in the hands of the membership. It is an important piece of paper, reminding physicians that they can be masters of their own house, fulfill professional obligations, work together for a fair shake in the free market, and put it all together in the interest of privately delivered quality medical care.—R.B.K.





"I've discovered the cause of that rattling in your chest."

Those Resourceful Cigarette Makers

Tobacco manufacturers are never lacking in resourcefulness. Four years ago, they weathered a legislative crisis when the Congress threatened to silence better taste over the radio and black out springtime on TV. Their astute lobbyists pushed a compromise through under which the first acknowledgement of potential harm was printed along the side of the pack: "Caution: Cigarette Smoking May Be Hazardous to Your Health." But they stayed on the air.

The ruse worked smoothly, as the man from Marlboro, young lovers amid flowers, and puffing athletes hawked coffin nails in prime time. But as the evidence mounted, the end came in sight. The Congress set a doomsday deadline to get cigarette advertising off the airwaves. Again, the fag makers brought off a beaut. They managed to get the deadline changed to Jan. 2 from Jan. 1, 1971. Result: $2 million in cigarette commercials during telecasts of New Year's Day bowl games.

Then came the new crunch on print media to which the cigarette business had been forced to turn. The tougher law not only requires the stronger admonition, "Warning: The Surgeon General Has Determined That Cigarette Smoking Is Dangerous to Your Health," on the pack but also in printed advertisements.

So, predictably, Madison Ave. took a new tack, printing the warning by showing a pack of fags lying flat (with the wording usually printed in deep tone, merging colors) and the flashy front of another standing on the recumbent requirement of the law.

And the era of the cigar came to television, too, because cigars and pipe tobacco are not taboo on radio and the tube. In addition to conventional size stogies for special people, racetrack stewards starting the derby, and big spenders (the minute you walked in the joint . . .), there are the tipped cigars fit to offer to a lady and the proliferating little cigars.

Now it looks as if the imaginative and resourceful industry is pulling off an end run around the law, the Federal Trade Commission, the Federal Communications Commission, and the Justice Department which is charged with enforcement of the electronic media ban. And of all the unlikely allies apparently helping the fag makers is the Internal Revenue Service.

It seems as if a new brand called Winchester is being test-marketed in two major cities, Boston and Dayton. The radio and TV ads proclaim that it isn't a cigarette and "not just another little cigar." But it is tobacco wrapped in paper with a filter delivered up in a soft pack of 20 each. The trick is that the paper contains reconstituted tobacco (a neat and profitable use for the stems which used to end up in the incinerator).

Winchesters sell for 23 to 27 cents a pack, quite a savings over cigarettes which are more than doubled in price by federal, state, and local taxes. Legally, however, Winchesters are a little cigar, because the Internal Revenue Service says so. You see, classification of tobacco products is a statutory function of IRS, since it is the tax collector. And the rate on cigars is only a fifth of the levy on fags.

Then there is the mixup in Washington: IRS does the classifying, FTC polices, FCC says what goes on the air, and Justice is supposed to prosecute violators. Winchesters may well be the most successful end run for the tobacco interests since the legislative ploy of four years ago with the slick compromise.

What's more, tobacco sales are up, despite the fact that the number of adult American males who smoke has dropped to 42 per cent from 52 per cent in 1966, some evidence that the health hazards of cigarettes is getting to the smoker. But cigarette sales are 10 per cent higher in 1971 than

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a year ago. The apparent conclusion is that fewer individuals are smoking more.

Down the line may come another shoot-out in the Congress, because the four executive agencies seem reluctant to take on the tobacco manufacturers. Meanwhile, we Americans—despite hard, convincing medical evidence—are puffing away more in dollars than we spend on physicians' services. With a lot of help from the tobacco industry, too.—R.B.K.

Meters or Feet, That Is the Question

A physician reviews laboratory findings on his patient, noting that hemoglobin level is 14 gm/100 cc, serum potassium is 4.4 mEq/liter, and serum phosphatase measured 2 units/100 cc. He writes a prescription, indicating a dosage strength in mg, based upon so many kg of body weight.

Then he leaves his office to drive two miles to the hospital in his 119-inch wheel base automobile which gets about 14 miles to the gallon in city traffic. He parks within 50 feet of the entrance. On his way home, he picks up five pounds of sugar and a quart of milk at the quick stop grocery.

This is the mixed up world of metric and English measure in which American physicians, physical scientists, and some manufacturers dwell. The United States is the last major nation in the world which has not converted to the metric system.

Devised by the French in 1795, the metric system of measure has been adopted by most nations of the world. The Bureau of Standards, Department of Commerce, recognizes the metric system, but the English system of inches, feet, and miles, ounces (fluid), quarts, and gallons, and grains, ounces, and pounds is the official U. S. system. The government is taking a hard and continuing look at changing to metric.

Few Americans realize that more than half of the treaties signed by the United States relate to weights and measures, usually specifying metric-English equivalents. And since conversion is a nightmare, it would be desirable—at least for international uniformity—to go metric.

A recent Gallup poll shows that 44 per cent of Americans know what metric measure is, up from 20 per cent in 1965. This has largely resulted from teaching metric measure in elementary and secondary schools, because two out of 10 college graduates in the recent poll didn't know what it is. Of those who know something of the metric system, 42 per cent favor changing to it, 42 per cent oppose change, and 16 per cent have no opinion.

Very likely, no complete change will come for a generation. Every building and house in this nation is measured in feet and inches. Land is surveyed and divided and legally recorded in the same manner. America's rolling stock of 110 million automobiles are all built and serviced on English system measure. Our industrial might—save for a small fraction oriented to scientific work—is keyed to English measure. So conversion would run into the billions of dollars, to say nothing of the confusion wrought among 206 million perplexed citizens. The chances are that we will continue officially English while expanding metric measure in those areas where it serves best.

Anyway, who wants to sit on the 20 meter line at the State-Ole Miss game?—R.B.K.



Dimetapp Extentabs®

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Limited to five registrants, each class is designed for family physicians enrolled in the Mississippi Postgraduate Institute in the Medical Sciences, which is supported by the Mississippi Regional Medical Program.

Nov. 1-5, 1971

RADIOLOGY INTENSIVE COURSE

University Medical Center, Jackson
Nov. 1-5, beginning at 8 a.m.

Sponsored by The University of Mississippi School of Medicine, with the support of the Mississippi Regional Medical Program

Coordinator:
Robert D. Sloan, M.D., professor of radiology and chairman of the department, The University of Mississippi School of Medicine

Registrants for this one-week intensive course will study radiologic procedures in the diagnostic, therapeutic and isotope areas, as well as review equipment, techniques, artifacts and radiation safety. In addition, they will participate in diagnostic conferences demonstrating practical points of radiographic interpretation.

Nov. 8-12, 1971

NEPHROLOGY INTENSIVE COURSE

University Medical Center, Jackson
Nov. 8-12, 1971, beginning at 8 a.m.

Sponsored by The University of Mississippi School of Medicine, with the support of the Mississippi Regional Medical Program

Coordinator:
John D. Bower, M.D., assistant professor of medicine, The University of Mississippi School of Medicine, and director, artificial kidney unit, The University of Mississippi Medical Center

This one-week intensive course is clinically oriented to emphasize the treatable and reversible forms of kidney disease. Registrants will study acute kidney failure and control of reversible features of chronic disease in depth. They will cover such areas as pyelonephritis, fluid and electrolyte problems and acid base balance, as well as hemodialysis in clinical nephrology.

Nov. 15-19, 1971

GASTROENTEROLOGY INTENSIVE COURSE
University Medical Center, Jackson
Nov. 15-19, 1971, beginning at 8 a.m.
Sponsored by The University of Mississippi School of Medicine, with the support of the Mississippi Regional Medical Program

Coordinator:
Lidio O. Mora, M.D., associate professor of medicine, The University of Mississippi School of Medicine, and chief, division of gastroenterology, The University of Mississippi Medical Center and the Jackson Veterans Administration Center

A practical view of gastroenterology, this one-week refresher course will emphasize management of conditions most commonly seen in office practice medicine. Curriculum will stress endoscopy of all kinds, especially rectal sigmoidoscopy. Registrants will participate in ward rounds at the University and the VA, seminars and lectures.

Nov. 29-Dec. 3, 1971

OBSTETRICS INTENSIVE COURSE
University Medical Center, Jackson
Nov. 29-Dec. 3, 1971, beginning at 8 a.m.
Sponsored by The University of Mississippi School of Medicine, with the support of the Mississippi Regional Medical Program

Coordinator:
Donald M. Sherline, M.D., associate professor of obstetrics and gynecology, director, division of obstetrics, and instructor of anesthesiology, The University of Mississippi School of Medicine

Offered for the first time in the Postgraduate Institute, this one-week intensive course will review current concepts of obstetrical practice, including fetal medicine, prenatal and intrapartum medical complications of pregnancy, and obstetrical anesthesia and analgesia. Participants will round, take part in medical complications clinic, attend seminars and conferences.

CIRCUIT COURSES

NORTHERN CIRCUIT

Clarksdale—Nov. 4—Session 2; Nov. 18—Session 3; Coahoma County Hospital, 7:30 p.m.
Session 2—Predialysis Management of Chronic Renal Disease, Dr. John Bower
Prevention and Surgical Management of Chronic Renal Disease, Dr. W. Lamar Weems
Session 3—Acute Abdominal Conditions in Infants, Dr. Richard Miller
Goiter in Children, Dr. J. M. Montalvo

FUTURE CALENDAR

November 1-5, 1971
RADIOLOGY INTENSIVE COURSE

November 4
CIRCUIT COURSE, CLARKSDALE

November 8-12
NEPHROLOGY INTENSIVE COURSE

November 15-19
GASTROENTEROLOGY INTENSIVE COURSE

November 16
PULMONARY DISEASE SEMINAR

November 18
CIRCUIT COURSE, CLARKSDALE

November 29-December 3
OBSTETRICS INTENSIVE COURSE

December 6-10
STROKE AND NEUROLOGICAL DISEASE INTENSIVE COURSE

January 10-14, 1972
ELECTROCARDIOGRAPHY INTENSIVE COURSE

January 11
CIRCUIT COURSE, MCCOMB

February 7-11
GASTROENTEROLOGY INTENSIVE COURSE

February 14-16
CARE OF ACUTE CARDIAC PATIENTS, BILOXI
MISSISSIPPI HEART ASSOCIATION

March 13-17
OBSTETRICS INTENSIVE COURSE
STROKE AND NEUROLOGICAL DISEASE INTENSIVE COURSE

March 20-24
CARDIOLOGY INTENSIVE COURSE

April 10-14
PEDIATRICS INTENSIVE COURSE

April 11
CIRCUIT COURSE, MCCOMB

April 24-28
RADIOLOGY INTENSIVE COURSE

May 1-5
NEPHROLOGY INTENSIVE COURSE

May 8-11
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

NEW MEMBERS

HOWELL, THOMAS ROBERT, Laurel. Born Ellisville, Miss., Feb. 15, 1936; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1965; interned Mobile General Hospital, Mobile, Ala., one year; residency in surgery, Roanoke Memorial Hospital, Roanoke, Va., Nov. 1968-Oct. 1969; elected Sept. 9, 1971, by South Mississippi Medical Society.

JOHNSON, CLEVELAND ERIC, Laurel. Born Memphis, Tenn., April 24, 1939; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1962; interned Philadelphia General Hospital, Philadelphia, Pa., one year; surgery residency, Kennedy VA Hospital, Memphis, Tenn., Jan. 1, 1966-July 1, 1966; orthopaedic surgery residency, Campbell Clinic, Memphis, Tenn., Jan. 1, 1967-Jan. 1, 1970; elected Sept. 9, 1971, by South Mississippi Medical Society.

PERSONALS

BROOKS ALLISON, originally from Greenville, has begun the practice of pathology at Oxford-Lafayette County Hospital in Oxford.

BLAIR E. BATSON, ALFRED W. BRANN, JR., HUGH B. COTTRELL, WILLIAM E. NOBLIN, JR., NELL J. RYAN, HENRY A. THIEDE, and MARY E. HAWKINS, all of Jackson, and JAMES A. SHEFFIELD of Gulfport attended a conference on birth defects sponsored by the March of Dimes in Miami.

THERESA L. R. BUCKLEY of Biloxi has been named president of the Harrison County unit of the American Cancer Society. Dr. Buckley limits her practice to ophthalmology.

JOEL T. CALLAHAN of Meridian presented a paper on endoscopy at the fall meeting of the District 16 Mississippi Nurses Association meeting at Matty Hersee Hospital.

BENJAMIN L. CRAWFORD, JR., of Tylertown is the new president of the Walthall County General Hospital medical staff. Other officers are Drs.

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Walter Crawford, vice president, and James L. McLain, secretary.

Robert L. Donald, Jr., of Pascagoula has been elected to the board of directors of the Mississippi Coast Crime Commission.

Bernard H. Ellis of Columbus has qualified as an independent candidate for the office of Lowndes County Coroner in the Nov. 2 General Election. Dr. Ellis is the first licensed physician to seek the post in modern years.

J. V. Ferguson, Jr., of Greenwood has been elected chief of staff of the Greenwood Leflore Hospital. Other officers include Drs. John Wofford, vice-chief; John Hey, secretary; and Fred M. Sandifer, Jr., member of the Executive Committee.

W. Douglas Godfrey of Jackson is the new president of the Hinds County Unit of the American Cancer Society. Other officers are Forrest G. Bratley, treasurer; and W. H. Merrell, Jr., assistant treasurer. George Ball is the immediate past president.

Lawrence Joseph Guidry, originally from Long Beach, announces the opening of his office for the practice of urology at 506 Forrest Avenue in Biloxi.

Carl R. Hale, Larry H. Day, Larry J. Hammett, and Robert H. McCrary of Hattiesburg are serving on the board of directors of the Lost Chord Club of South Mississippi.

Conrad C. Horecky, III, has associated with Hannelore H. Giles of Hattiesburg for the practice of internal medicine at 990 Hardy Street.

John V. James of Yazoo City has announced his retirement after practicing medicine in Yazoo County for nearly 37 years. For the past 12 years, Dr. James has been serving as county health officer.

R. E. Jennings of Taylorsville is currently serving as president of the Smith County Heart Association.

William A. Long, Jr., of Jackson was keynote speaker at the Narcotics Education Forum held at Greenwood High School auditorium.

Ross Brown Love of Tupelo won the trophy for being first to bag the limit of 12 birds at the annual dove shoot hosted by the North Mississippi Medical Center.

Robert H. McCrary has associated with James E. Harris, Larry J. Hammett, and Larry H. Day of Hattiesburg for the treatment of diseases of the ear, nose and throat at Suite 101, Medical Plaza Building.

Frank J. Morgan, Jr., assistant state health officer, has gone to the University of Texas School of Public Health at Houston to begin one year of training for the Master of Public Health degree.

W. L. Rone and W. F. Lynch, Jr. of Jackson announce the opening of their office for the practice of diagnostic radiology at Medical Tower Suite 104, 440 E. Woodrow Wilson Drive in Jackson. Drs. Rone and Lynch recently incorporated to form Jackson Radiology Associates, P.A.

Jetson P. Tatum of Meridian was installed chairman of the Southern Regional Heart Committee and vice-president of the American Heart Association at the MHA fall meeting in Biloxi.

David J. Vanlandingham of Jackson was guest speaker at the Central Chapter of Mississippi Association of Medical Assistants meeting in Jackson. Dr. Vanlandingham spoke on the Bible and medicine.

Joe W. Walker, formerly of Trenton, Tenn., has begun the practice of internal medicine and cardiology in Water Valley. Dr. Walker's office is in the Spears Clinic on Main Street.

J. Kinabrew Williams, Jr., of Pascagoula has been appointed chairman of the Gulf Island's National Seashore Advisory Commission. The commission will advise the Department of the Interior on the administration and development of the nearby offshore islands of Mississippi and northwest Florida.

John E. Williams, a native of Jackson, has joined A. C. Hewes and E. C. Hamilton of Gulfport in the practice of general surgery at 14th Street and 25th Avenue.

DEATHS

No reports of deaths in the association were reported to the Journal during the month of October 1971.

Book Reviews

Medical Laboratory Technology and Clinical Pathology. Second Edition. By Drs. M. J. Lynch, S. S. Raphael, L. D. Mellor, P. D. Spare and M. J. Inwood. 1,359 pages with illustrations. Philadelphia, W. B. Saunders Company, 1969.

Any book intended as a conpendium of knowledge in the field of clinical pathology today certainly has its work cut out for it. For the undergraduate and graduate students of medical laboratory technology and laboratory medicine, *Medical Laboratory Technology and Clinical Pathology* is a good book. A great deal of its contents is devoted to the divisions of clinical laboratory knowledge; chemistry, urinalysis, hematology and microbiology, providing background pathophysiologic information followed by technical information and technical procedures.

The discussion of the usual tests is presented in a format of principal, procedure, interpretation, reagents and special notes. Thus a concise and useful order of information is available on this important subject.

An excellent section, 244 pages of its 1,359 pages, is devoted to facets and essentials of histologic techniques, even at a time when histo-technology is being dropped from the general curriculum of medical technology schools. For those who are interested in histologic techniques or who need this information, this book is worthy of consideration for this section of material.

A series of filmstrips is available as visual supplement in conjunction with the use of this book in teaching. These have not been reviewed, but will be most likely of considerable parallel value in medical technology teaching programs.

Although the book is quite complete in the area of technical procedures and information, clinicians will find it of great value as a reference toward better understanding of reported laboratory test results. This will enable the practicing physician to achieve more complete correlative use of laboratory data.

WILLIAM D. ATCHISON, M.D.

Review of Medical Physiology. Fifth Edition. By William F. Ganong, M.D. 573 pages with illustrations. Los Altos: Lange Medical Publications, 1971. $8.50.

In the preface, Dr. Ganong describes this as being "A concise summary . . . of human physiology." While one may question the term "concise" being used for a book in excess of 550 pages, the book is a summary of mammalian and human physiology and probably an adequate one at that. In this day of rising medical textbook prices, it is encouraging to find a good one selling for less than $10.00.

This is a soft back monograph following the style of the other Lange review publications. It is divided into eight sections covering the gamut of medical physiology. Each section is divided into several chapters. Representative chapter titles include: "Neurophysiologic Basis of Instinctual Behavior and Emotions," "Gastrointestinal Motility and Secretion," "Cardiovascular Homeostasis in Health and Disease," and "Regulation of Extra Cellular Fluid Composition and Volume."

Each section is followed by a group of references. As an example, the section on Endocrinology and Metabolism is followed by 55 references dating from 1956 through 1971 including symposia and review articles. The appendix includes a list of newer revised comprehensive textbooks of physiology such as Best & Taylor and Guyton.

A list of commonly used abbreviations and symbols is noted in the appendix. The index seems to be complete and adequate. The text is filled with drawings, graphs, formuli and charts which well illustrate the written material. The greatest shortcoming of the book probably lies in the reproduction of pictures. There are not a large number of them and the ones present are poorly reproduced. Most are adequate, but in some such as the illustration of "Dopamine in nerve endings in the median eminence" on page 182, it is difficult to see what is being illustrated.

If one is interested in a review book for Board or exam preparation or merely to read for one's own interest, I believe I can recommend this book. However, it is not adequate for, nor intended to be used by, students in physiology as their sole reference.

DAVID M. OWEN, M.D.



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Two UMC Students Receive SMA Awards

Steven E. Calvert and Charles S. Watras, students at University of Mississippi School of Medicine, have been awarded Medical Student Scholarships by Southern Medical Association.

The students were two of 26 scholarship recipients chosen from throughout SMA's territory of 16 southern states and the District of Columbia. The scholarships are conferred annually to provide assistance to first-year medical students of superior ability.

In keeping with its primary objective to develop and foster scientific medicine, SMA established the Medical Student Scholarship Fund in 1969.

Headquartered in Birmingham, Ala., Southern Medical Association is comprised of more than 20,000 physicians. The group's 65th Annual Meeting, an expansive session of scientific exhibits and seminars, will be held this year in Miami Beach, Nov. 1-4.

ACP Plans Hematology Course

The American College of Physicians will sponsor a three-day postgraduate course on "Solving Problems in Clinical Hematology" Nov. 17-19 in Birmingham, Ala. in the Veteran's Administration Hospital.

The Birmingham course is one of some 25 the College holds annually in the United States and Canada. Their purpose is to give specialists in internal medicine and related specialties the opportunity to review their knowledge in a particular area of interest and to keep informed of new developments in the basic and clinical sciences that affect their practices. The courses have been held annually since the mid-1930s.

During the three-day course, physicians, in small group discussions, will examine in depth nine areas of clinical hematology. These include blood proteins, problems in clotting, synthesis of the hemoglobin, nutritional hematology, leukemia, pediatric blood diseases, hematologic aspects of immune deficient diseases, cancer of the lymph tissues and the hemolytic anemias.

Co-directors of the course are Dr. John R. Durant, Birmingham, professor of medicine and director, University of Alabama Cancer Research and Training Program and Dr. Walter B. Frommeyer, Jr., Birmingham, professor of medicine and distinguished professor at the University of Alabama.



A State of Mississippi ambulance helicopter landing started Health Expo I off with a bang as hundreds of school children, teenagers and other guests gathered around the landing site. Lower photo shows Governor John Bell Williams and Dr. Arthur E. Brown of Columbus, MSMA president, being greeted upon embarking from the chopper.

VIPs Open Expo I . . .





50,000 See Our Exhibits . . .



The association's "Life Begins" exhibit on teenage sex education was so popular that the photographer couldn't even get close. Lower left, Dr. Hugh B. Cottrell, state health officer, views MSMA mechanical quackery presentation. The association sponsored five exhibits in the giant health fair which attracted some 50,000 people to view exhibits and films and participate in screening.



Including Important Leaders . . .

Governor Williams was the honored guest of Expo leaders at opening day ceremonies. From left are Dr. Brown, Gov. Williams, Mrs. Guy T. Gillespie, Jr., and Dr. Robert E. Blount, UMC dean and director. Lower right, distinguished keynote speaker was Dr. Robert Q. Marston of Bethesda, Md., director of the National Institutes of Health and former dean of the Mississippi medical school.

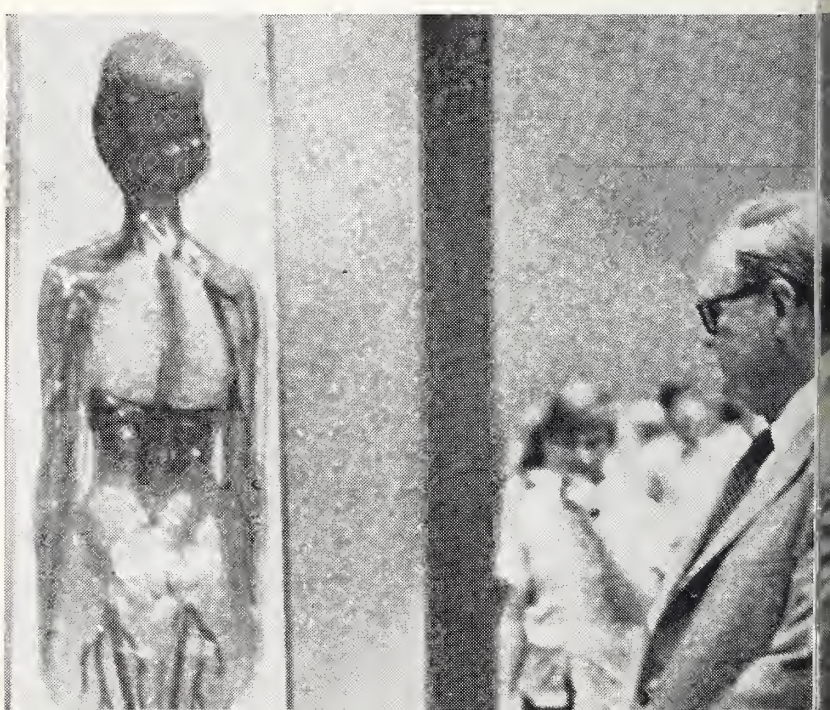


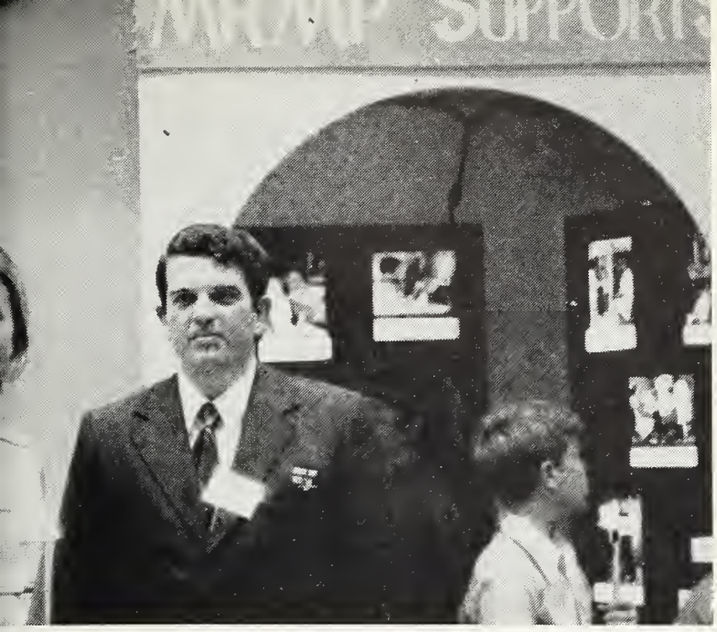


Members and Wives Participate . . .

Community and medical leaders behind the Expo effort were on hand as activities got underway. From left are Dr. Raymond S. Martin, Jr., association secretary-treasurer; Dr. E. Leonard Posey, Jr.; and R. Ben Lampton, president of Jackson's First National Bank. Lower left, the Woman's Auxiliary sponsored a booth on health careers with medical and nursing students present to discuss possible careers with visitors. Mrs. J. Gordon Dees and Bill Gibson, UMC senior, finalize plans. Lower right, Dr. C. G. Sutherland, chairman of the MSMA Expo I committee, examines the "Transparent Woman," a well attended association exhibit.









Upper left, Dr. T. D. Lampton, coordinator of the Mississippi Regional Medical Program, and Miss Judy Cole, staff secretary, look over the MRMP presentation which showed the different training programs RMP supports. Upper right, Dr. William F. Pontius of Canton, president of Central Medical Society, explains the MSMA display on the brain and nervous system to Mrs. Nancy Varnado, Central's executive secretary. Lower right, Dr. John D. Bower, center, UMC Artificial Kidney Unit director, and Dr. Robert W. Frasier, right, urology resident, discuss the unit with Dr. Eric A. McVey, Jr., Hinds County health officer.

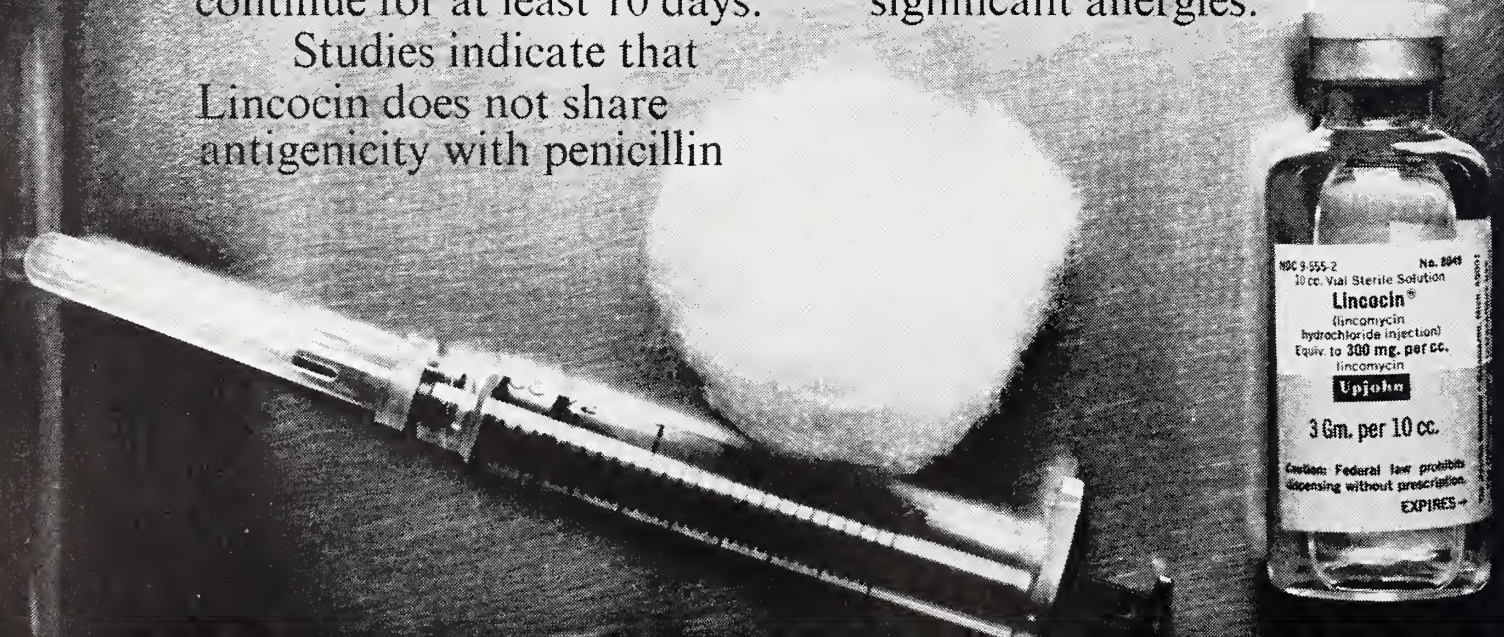
56 Organizations Represented . . .



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Studies indicate that Lincocin does not share antigenicity with penicillin compounds. However, hypersensitivity reactions such as angioneurotic edema, serum sickness and anaphylaxis have been reported, some of these in patients known to be sensitive to penicillin. As with any antibiotic, Lincocin (lincomycin hydrochloride, Upjohn) should be used cautiously in patients with histories of asthma or other significant allergies.



MHA Schedules Cardiac Care Course

The Mississippi Heart Association will sponsor a three-day physician seminar in Modern Management of the Acute Cardiac Patient, Feb. 14-16, 1972, at the Sheraton of Biloxi Motor Inn.

The MHA Coronary Care Committee, chaired by Dr. William H. Rosenblatt of Jackson, is planning the program.

For further information write Mrs. Pat Roundtree, MHA, P.O. Box 16063, Jackson, Miss. 39206.

Medical Aspects of Sports Conference Set

The 13th National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in New Orleans at the Jung Hotel on Nov. 28, 1971. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

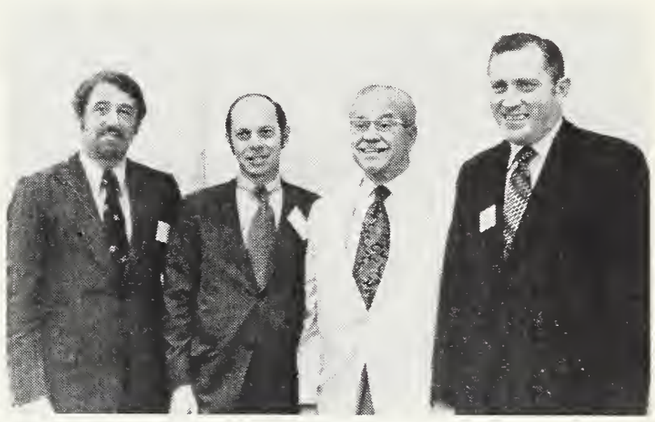
The conference will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums and discussion sections relating to drugs in sports, protection of the lower extremities, electrolyte and thermal balance, innovations in sports medicine through state medical societies, team physician relationships, crucial health perspectives, and a medical focus on athletics.

At the Conference Luncheon, Dr. W. Delano Meriwether, winner of the J. D. Lane Annual Research award for his work at the National Cancer Institute in Baltimore and presently a researcher at the Harvard Medical Unit, Boston; and a latent sprint champion, will discuss "My Experiences as a Neophyte Track Athlete."

At the evening session, demonstrations will be staged on taping, equipment fitting, vision, emergency resuscitation and pre-participation examinations.

The Conference is open to key non-medical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the Conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

Dr. Long Attends Journal Conference



Dr. Lawrence W. Long of Jackson, chairman of the MSMA publications committee, discusses the drug advertising situation with key participants in the 1971 State Medical Journal Advertising Bureau Biennial Journal Conference held recently in New Orleans. From left are Hon. Bruce J. Brennan, vice president and general counsel of the Pharmaceutical Manufacturers Association; Hon. Sherwin Gardner, assistant commissioner of FDA; Dr. Long; and Congressman Charles Griffin, 3rd District, Mississippi.

Southeastern Internists Plan Meeting

The American College of Physicians (ACP) will hold a scientific-educational meeting for specialists in internal medicine and related fields in six southeastern states Oct. 7-9. The meeting is set for the Sheraton-Ft. Sumter Hotel, Charleston, S. C.

The Southeastern regional meeting is one of 40 scientific-educational meetings the College is sponsoring during the 1971-72 academic year. Held throughout the United States and Canada, the meetings help the College's 17,000 members keep informed of new knowledge and developments in the basic and clinical sciences that affect their practices. The College has been sponsoring these regional meetings annually since 1930.

The Southeastern meeting is for internists in Alabama, Florida, Georgia, Louisiana, Mississippi and South Carolina. It is being planned under the general direction of Dr. Vince Moseley, Charleston, S. C., ACP Governor for South Carolina and professor of medicine and director of the Division of Continuing Education at the Medical University of South Carolina.

Dr. Boshell Heads UAB Diabetes Division

Dr. Buris R. Boshell has been appointed director of the newly-formed Division of Diabetes, Endocrinology and Metabolism in the UAB School of Medicine.

The announcement was made by Dr. T. Joseph Reeves, chairman of the department of medicine, and Dr. Clifton K. Meador, dean of the School of Medicine at the University of Alabama in Birmingham.

Dr. Boshell is UAB's Ruth Lawson Hanson Professor of Medicine in Diabetes and Metabolism and served as director of the Division of Diabetes and Related Disorders until it was merged with the Division of Endocrinology and Metabolism.

Dr. Boshell, who serves as president of the board of directors of the Diabetes Trust Fund of Alabama, is a former president of the Alabama Diabetes Association. He is responsible for almost single-handedly marshalling support for construction of the nation's first public diabetes hospital. The $2.4 million facility, which will be a permanent research, detection, education, and treatment center, will be available to Alabama as well as to patients from throughout the world. It is being built now as the first unit of University Hospital No. 2 in the UAB Medical Center.

Dr. Boshell earned the M.D. degree from Harvard Medical School in 1953, after receiving his first two years of medical training at the UAB School of Medicine.

Dr. Boshell served his internship and residency at Boston's Peter Bent Brigham Hospital and from 1956-58 was a research fellow in medicine at Harvard. He is currently director of diabetic research at the Birmingham Veterans Administration Hospital.

A fellow of both the American College of Physicians and the American College of Clinical Pharmacology and Chemotherapy, he serves on the editorial board of the journal, "Clinical Research," is a regional evaluator for the residency review committee of the American Medical Association, a regional representative for admission applications of Harvard Medical School, and an abstractor for the national journal, "Diabetes."

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Medicare Raises Hospital Deductible

Beginning in Jan., an older person who goes to the hospital under Medicare will be responsible for the first $68 of his hospital bill—now running about $800 for the average stay by a Medicare beneficiary.

The present hospital deductible is $60 and will remain in effect for all Medicare hospital admissions during the remainder of this year.

In announcing the 1972 deductible, Secretary of Health, Education, and Welfare, Elliot L. Richardson, explained that since hospital costs in calendar year 1970 rose substantially, he is compelled under the law to set a new deductible to become effective next Jan. The law provides a specific formula for computing the amount of any adjustment in the deductible, he said, and also requires that notice of the upcoming deductible amount be promulgated on or before Oct. 1.

"The action I was required to take today," Secretary Richardson said, "further emphasizes the urgency of action to put a brake on hospital cost escalation." He urged early enactment of H.R. 1, the welfare reform bill now pending before Congress, which includes provisions aimed at controlling health care costs, not just for the Medicare and Medicaid programs but for all consumers.

In addition, he urged early action on the Administration's health program, including its National Health Insurance Partnership Act and Health Maintenance Organization Assistance Act, which also aim at controlling health care costs.

With respect to this announcement, Secretary Richardson said the hospital deductible amount is intended to make the Medicare beneficiary responsible for expenses equivalent to the average cost of one day of hospital care.

Under the formula in the law, the new hospital deductible is based on the ratio between hospital costs in the previous year (1970) and costs in 1966, the first year of Medicare operation. That ratio is then multiplied by $40 and the result rounded to the nearest $4. The result is an increase from $60 to $68.

When a Medicare beneficiary has a hospital stay of more than 60 days, he will pay $17 a day for the 61st through the 90th day, up from the present $15 per day. If he has a posthospital stay of over 20 days in an extended care facility, he will pay $8.50 per day toward the cost of the 21st day through the 100th day, up from the present $7.50 per day.

If he needs to draw on his "lifetime reserve," the reserve of hospital days a beneficiary can draw upon if he ever needs more than 90 days of hospital care in the same benefit period, he will pay $34 for each day used, instead of the present $30 per day.

Cancer Society Elects Officers



Dr. Daniel T. Keel of Brookhaven, left, is the newly elected president of the American Cancer Society, Mississippi Division. Dr. Frank A. Wood of Jackson, right, was named president-elect of the Society, and Dr. Loren Breland of Crystal Springs was elected first vice-president. The three physicians assumed their new duties at the September annual meeting of the Cancer Society.

Family Practice Board Announces Next Exam

The American Board of Family Practice announces that it will give its next examination for certification in the various centers on April 29-30, 1972.

Deadline for receiving completed applications in the Board office is Feb. 1, 1972.

For further information, write Dr. Nicholas J. Pisacano, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.


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Adverse Reactions: Side effects reported to date have been predominantly related to rash (which requires discontinuation of medication) and headache and gastrointestinal distress, which are usually mild and transient with continuation of medication. In some cases severe persistent headaches may occur. In addition, the following adverse reactions to nitrates such as pentaerythritol tetranitrate have been reported in the literature: (a) Cutaneous vasodilatation with flushing. (b) Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. (c) An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur, even with the usual therapeutic doses. Alcohol may enhance this effect.
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PE-GP-11

College of Nutrition Plans Nov. Meeting

The twelfth annual meeting of the American College of Nutrition will be held in New Orleans on Nov. 28, 1971, in the Grand Ballroom of the Royal Sonesta Hotel.

The one-day program includes a symposium on hyperlipidemias and atherosclerosis and a discussion of nutrition in outer space.

This meeting is scheduled for the day preceding the AMA clinical convention in New Orleans. Hotel reservations should be made through the AMA Housing Bureau.

Medical Assistants Are Certified

A record number of medical assistants have passed the 1971 certification examination. The names of 169 successful examinees have been announced by the American Association of Medical Assistants. Examinations were held in June at 42 testing centers across the nation.

Of the 169 certificates earned, 77 were clinical certification, 52 administrative, and 40 dual. Nine of the individuals earned a CMA in a secondary category, while 160 were certified for the first time.

The certification examination is a professional goal signifying board mastery of AAMA's standards for highly qualified medical assistants. It may be attained in either the clinical or administrative categories, or both. The complete examination for dual certification covers medical terminology, anatomy and physiology, human relations, medical ethics and law, office skills, accounting, examination room techniques and laboratory orientation. The program was developed in 1961 with the first examination held in 1963. Merck, Sharp and Dohme has assisted in supporting the program annually since 1962.

The AAMA Certifying Board will host a dinner honoring the new CMA's on Nov. 10, as part of the 15th annual convention in Atlanta, where certificates and pins will be issued.

At the present time Mississippi boasts one Certified Medical Assistant, Mrs. Mary Adeline Pace, administrative assistant to Dr. Marvin Jeter of the University Medical Center in Jackson. There were no '71 applicants from Mississippi, but several assistants are planning to take the examination in 1972.

Arthritis Management Course Planned

The Arthritis Foundation is sponsoring a course, "Management of Arthritis: Patients and Patience," on Nov. 18-19 in New Orleans.

Held in conjunction with the Interstate Postgraduate Medical Association of North America scientific assembly, the course will be acceptable for American Academy of General Practice credit.

The Thursday morning session will take place at The Rivergate, North Hall. Following a luncheon at the Roosevelt Hotel with guest speakers on quackery and arthritis, participants will reconvene in the Grand Ballroom of the Roosevelt Hotel.

There will be a $5.00 registration fee for those not registered at the Interstate meeting. For further information write The Arthritis Foundation, 1212 Avenue of the Americas, New York, N. Y. 10036.

SBH Predicts High Incidence of Flu

Evidence points toward a year of high incidence of influenza in Mississippi, according to Dr. Durward Blakey of the State Board of Health.

The state preventable disease control director said that the past "flu season" was the mildest since surveillance was started in 1957, but that late in the spring Type A virus was identified in several outbreaks in the state.

"Judging from prior surveillance experience, this evidence points toward a year of high incidence," he stated. Dr. Blakey pointed out that periodically true epidemics of influenza are associated with antigenic variation—called mutation—of the viruses but that this has not occurred during the past few years.

"So little change occurred in the prevalent strains last year that no change has been made in the virus component of this year's vaccine," he said "Consequently, persons with prior vaccination require only a booster this year."

Dr. Blakey expects the prior level of immunization to help minimize the impact of the virus in the state.

"We should expect," he said, "a rather high 'background' of upper respiratory conditions upon which influenza virus will occur in localized, sporadic outbreaks which may extend to include contiguous communities and counties."

Persons in the high-risk group, which in the past has shown a high mortality from influenza, should be vaccinated, Dr. Blakey advises.

Composing the high-risk group are persons over 65 years of age and the chronically ill of all ages who suffer from cardiovascular, renal, pulmonary or metabolic diseases.

Also included in the high-risk group are persons living in nursing homes, chronic disease hospitals and other hospital facilities where living arrangements would facilitate spread of the disease.

"For the general population, vaccination is not specifically recommended," said Dr. Blakey. "Nor is it recommended for children."

However, Dr. Blakey encourages businesses and industries that wish to protect against high absenteeism and subsequent disruption of service to make vaccine available to employee groups.

"Occupational groups concerned with public services who have made a practice of annual vaccination should certainly continue this fall," stated Dr. Blakey.

The State Board of Health is in the process of acquiring and distributing 300,000 doses of vaccine, he said.

"This vaccine is already allocated for administration to persons meeting the high-risk criteria and who are enrolled in health department programs," Dr. Blakey noted. "The governing criterion is that of being enrolled in one of the high-risk programs of the health department."

As to vaccine dosage, Dr. Blakey said that those who received vaccine last year need only a booster this year. Otherwise, two doses, two months or more apart, are advised. Immunization, he said, should be completed by Dec. 1.

"Even though vaccination is an accepted method for prevention of influenza, the current vaccines are not able to confer full or absolute immunity," Dr. Blakey pointed out.

Two vaccines are generally available this year, he said. Both are bivalent and contain the same antigenic formula. One is what he calls the "familar standard and the other is the new highly purified vaccine which causes fewer side reactions."

Surveillance of the occurrence of the flu-like syndrome will be maintained this year as usual, Dr. Blakey said.

"Health departments, physicians, schools, industries and institutions will be reporting any unusual outbreaks of illness or absenteeism and appropriate investigational studies will be undertaken to establish cause."

Medical Assistants Meet in Atlanta

A forum on the future of medical assisting, with special emphasis on education, will highlight the 15th annual convention of the American Association of Medical Assistants. The meeting, utilizing the theme, "Age of Achievement," will be held Nov. 9-13 at the Marriott Hotel in Atlanta.

After a two-day session of the House of Delegates, the educational program will begin on Thursday, Nov. 11, with a three-part presentation on the radical treatment of kidney failure. Dr. John H. Sadler, director of the Atlanta Regional Nephrology Center, will open the session with a discussion of "Kidney Failure: Artificial and Transplanted Organs."

His talk will be followed by "The Right to Live: The Price of Survival," presented by Dr. Elbert P. Tuttle, director of the Division of Nephrology and Inorganic Metabolism, Emory University School of Medicine, Atlanta.

During this same session a team from the Atlanta Regional Nephrology Center will discuss "The Right To Die: To Walk Not Alone." This unique section of the program involves people from various occupations who will show medical assistants how they can help the patient and his relatives cope with terminal illness.

On Nov. 12 Orie E. Myers, Jr., director of Woodruff Medical Center, Emory University, will open the educational session with a discussion on the "Human Relations Factor in Medical Assisting." Next, a panel on "The Age of the 80's" will be moderated by Dr. David G. Welton, Charlotte, N. C., member of the AAMA Physician Advisory Board. Topics to be covered are national health care insurance, the current status of AAMA's educational program, legislation, public relations and membership growth.

Panel participants include Wesley J. Duiker, director of the office of allied health manpower, American Academy of Pediatrics; William Goddard, executive director, National Association of Trade and Technical Schools; Leo E. Brown, assistant to the executive vice president, American Medical Association (AMA); Bernard P. Harrison, J.D., director of the division of medical practice, AMA; and LeRoy Wm. Natress, Jr., Natresources, Inc., educational consultant to AAMA.

The afternoon session will conclude with a special seminar presented by the AAMA education committee, "Achievement through Education." Representatives from the National Medical Audiovisual Center in Atlanta will discuss development and programing of audiovisual aids.

AAMA is a national organization of 14,000 medical assistants and secretaries, technicians, receptionists, bookkeepers, office managers and other personnel. They work under the direct supervision of a physician, serving as the direct link between him and his patients, associates and the suppliers of equipment and medications. The major objective of the association is to continue to increase the education and professionalism of medical assistants.

Delegates and alternates from Mississippi will be Mesdames Evelyn Wright, Tupelo; Rae Carter, Greenwood and Vicksburg; Colleen Waycaster, Tupelo; Helen Donohoo, Gulfport; Diane Ruscoe, Greenwood; and Mary Majure, Union. Also representing the state will be Mrs. Thelma VanCloostere, Long Beach, state president; and Mrs. Mary Brooks, Jackson, Central Chapter president-elect.

Dr. T. H. Alphin Appointed at UAB

The chief administrator of Alabama's Medicaid program has joined the Medical Center of the University of Alabama in Birmingham (UAB) as assistant to the vice president for health affairs.

Dr. Thomas H. Alphin, since 1968 the director of medical services for the State Department of Public Health, was also appointed professor of public health and epidemiology, according to Dr. S. Richardson Hill, Jr., UAB health affairs vice president.

Dr. Alphin will coordinate UAB programs in health economics and health insurance. "In addition, he will work with UAB faculty in the possible development of new types of health service delivery programs, both for UAB and for other groups served by UAB. He will also participate in health economics education programs for the UAB health schools and the UAB Hospitals and Clinics," said Dr. Hill.

The second vice president of the Equitable Life Assurance Society of the U. S. from 1958-68, Dr. Alphin's career has included executive posts with the American Medical Association, the Federal Civil Defense Administration, and the Virginia Department of Health. He has taught at the Universities of Virginia, Missouri, and Washington and Lee.

Dr. Alphin received his M.D. degree from the University of Virginia. He is an emeritus life member of the Medical Society Executives Association and has been a fellow of the American Geriatrics Society and the Industrial Medical Association.

ACCP Announces Essay Contest

The American College of Chest Physicians announces the 1972 Alfred A. Richman Essay Contest. The annual contest is designated to encourage undergraduate medical students to explore and investigate problems relating to the disciplines of the chest, and to present their findings in open competition for the benefit of other students and investigators.

Research or review articles relating to the diagnosis or treatment of cardiovascular or pulmonary disease are acceptable. In accordance with the rules of the contest, preceptors are at liberty to assist the student in selecting a suitable subject and guide him in the preparation of his essay.

Three cash prizes totaling $1,000 are awarded annually. First prize will be $500; second prize, $300 and third prize, $200. Each winner will also receive a certificate of merit. The medical school attended by the first prize winner will be awarded a trophy inscribed with the name of the student and the school.

Announcements to the winners will be made following the decision of the judges in May, and subsequently, awards will be presented at the Annual Meeting of the College in Oct.

The deadline for entering this year's competition is March 31, 1972. The official application form may be secured by writing Essay Contest, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill.

Gynecic Society Elects Officers

The Jackson Gynecic Society has elected its 1971-72 slate of officers.

Dr. Calvin T. Hull is the new president and Dr. George Ball was elected vice president. Dr. Lewis D. Lipscomb will serve as secretary-treasurer.

The society is a scientific organization made up of obstetricians and gynecologists from the greater Jackson area. It pioneered in the cervical cancer detection program.



NHLI Awards Lipid Research Contracts

The Lipid Metabolism Branch of the National Heart and Lung Institute has awarded seven contracts totalling $2.6 million for the establishment and support of six Lipid Research Clinics and a Central Patient Registry and Coordinating Center at medical institutions in various parts of the country.

The awards were announced by Dr. Robert I. Levy, Chief of the Lipid Metabolism Branch. Additional clinics are expected to be established in the future.

The Lipid Research Clinics will carry out targeted research directed toward the prevention of premature atherosclerosis through the identification and treatment of individuals rendered highly susceptible to the disease by blood-lipid abnormalities. Elevated levels of cholesterol and other fatty substances, collectively called lipids, are, with few exceptions, strongly associated with increased risk of atherosclerosis (so-called hardening of the arteries) and such consequences of the disease as heart attacks and strokes.

During the past 6 years, research studies involving more than 2,500 patients by scientists and clinicians of the NHLI's Molecular Diseases Branch and elsewhere have established that elevated blood lipids may be indicative of at least five different disorders—designated as hyperlipoproteinemias Types I through V—with each type differing from the other in clinical manifestations, risk for the patient, and responsiveness to therapy. This research has also resulted in 1) effective means for differentiating among these lipid-transport disorders by lipoprotein analysis or other simpler techniques and 2) development of therapeutic diets, supplemented as necessary with specific lipid-lowering agents, that can completely correct or substantially improve the lipid-transport abnormality to nearly all instances.

The research to be carried out by the new Lipid Research Clinics will represent a logical extension of this research and is designated to improve the detection and clinical management of hyperlipoproteinemias in the U. S. population.

In addition, the Lipid Research Clinics will seek to improve the detection, diagnosis, and clinical management of hyperlipoproteinemias by providing assistance and guidance to practicing physicians; facilitate the collection and dissemination of new information on these disorders through central pooling of data and use of common protocols; and seek further improvements in diagnostic and therapeutic procedures.

The recipients of the contracts are Stanford University, Stanford, California; University of California, San Diego; University of Washington, Seattle; Johns Hopkins University, Baltimore, Maryland; University of Alabama, Birmingham; and Baylor University College of Medicine, Houston.

PMA Clarifies Drug Prescribing

Clarifying drug prescribing is the basic message in a new 16-page booklet for consumers released by the Pharmaceutical Manufacturers Association.

Entitled, "When It Comes to Rx Medicines, There Are a Lot of Questions You Should Ask," the colorful pocket-size booklet examines the methodology of prescribing and some of the long-standing controversies related to it.

The booklet is primarily a condensation of another PMA document published earlier this year for health professionals and for those concerned with America's health care delivery system. While the earlier book, *Brands, Generics, Prices and Quality—The Prescribing Debate After a Decade* (May, 1971), was prepared to provide information that is essential in forming public policy, the purpose of the shorter pamphlet is to educate the patient, as a consumer.

"Many of the issues have been noisily garbled," said PMA president, C. Joseph Stetler. "So with this book, we have attempted to place some of the questions in perspective for the average consumer."

"About 90 per cent of the prescribing is done by trademarked name," the booklet notes. "Given the variety and subtlety of disease, variations in patient response, the range of products available and the natural tendencies of doctors to rely on companies with which they are familiar, this is hardly surprising."

"Hence, it is the consumer who should insist upon high standards of quality and upon strong private support for creative research against disease. Such encouragement can do much to assure success in improving today's medicines and in seeking tomorrow's," the booklet concludes.

Copies of the booklet are available upon request from the Public Relations Division, Pharmaceutical Manufacturers Association, 1155 Fifteenth St., N. W., Washington, D. C. 20005.

The PMA represents firms that make about 95 per cent of the nation's prescription medicines.

Southeastern Internists Plan Regional Meet

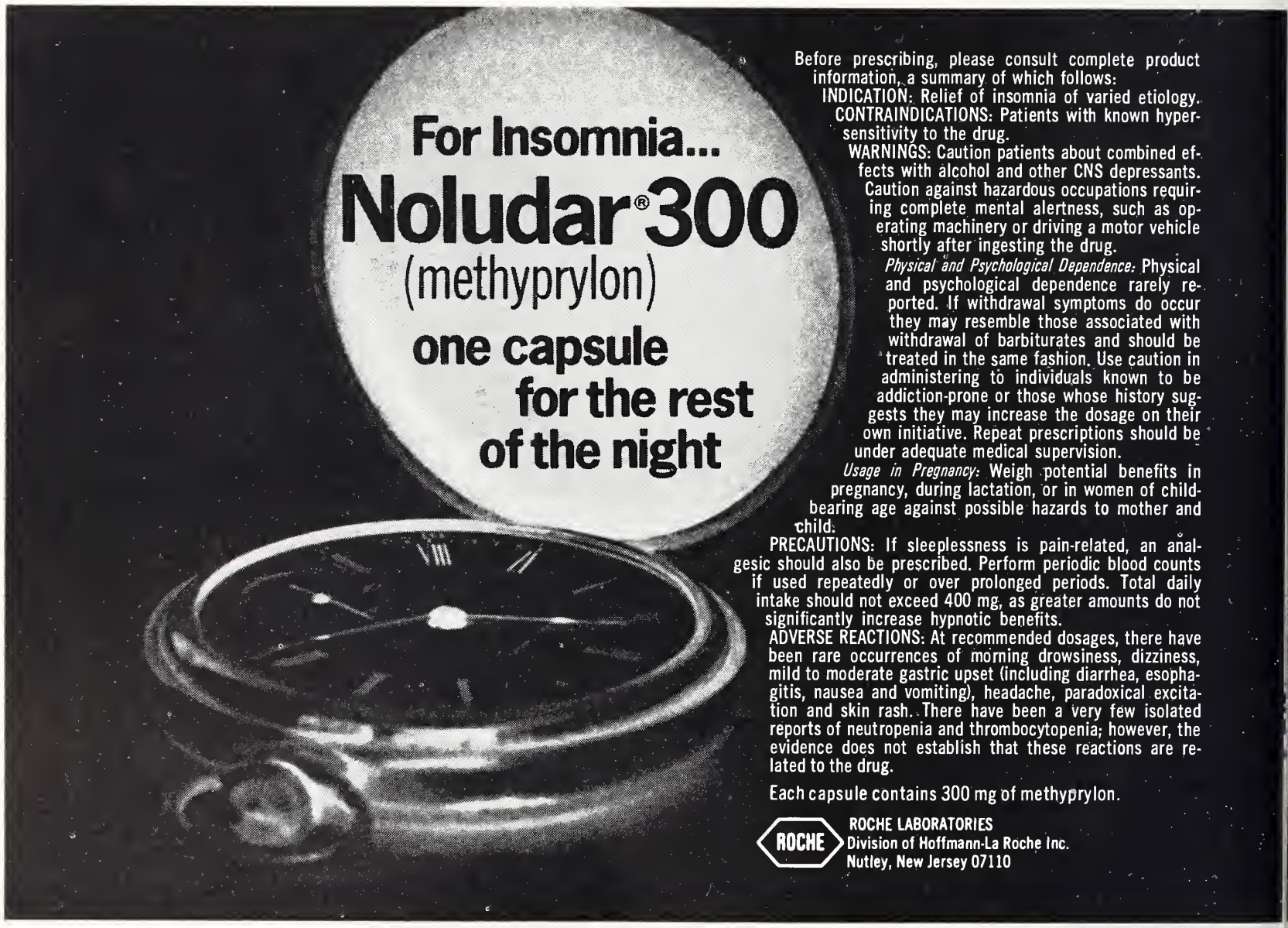
Specialists in internal medicine and related fields from six southeastern states will meet Oct. 7-9 for their annual scientific-educational meeting. The meeting, sponsored by the American College of Physicians will be held at the Sheraton-Ft. Sumter Hotel in Charleston, S. C.

Basic and clinical research reports on new ways of diagnosing and treating patients and new knowledge about a variety of diseases will highlight the program. The regional meeting is one of 40 the College is sponsoring during the 1971-72 academic year for its 17,000 members throughout the United States and Canada. Its purpose is to help internists in South Carolina, Florida, Alabama, Mississippi, Louisiana and Georgia keep informed of new knowledge and developments in the basic and clinical sciences that affect their practices. The College has been holding these regional meetings annually since 1930.

Among scientific reports will be ones on the management of patients with cancer, progress in Hodgkin's disease, clotting disturbances, high blood pressure and other cardiovascular problems, ulcerative colitis, thyroid regulating mechanisms, the diagnosis and treatment of headaches, acid-base regulation in kidney and pulmonary diseases, cellular immunology and blood studies in rheumatic diseases.

Course director is Dr. Vince Moseley of Charleston. Dr. Moseley is Coordinator of the South Carolina Regional Medical Program and Professor of Medicine and Director of the Division of Continuing Education at the Medical University of South Carolina.

He is being assisted by ACP Governors for the other southeastern states: Drs. Howard Holley, Birmingham, Ala.; Donald F. Marion, Miami; Tully T. Blalock, Atlanta; A. Seldon Mann, New Orleans, and Wesley W. Lake, Pass Christian, Miss.



ACP Sponsors Hematology Course

The American College of Physicians will present "Solving Problems in Clinical Hematology," Nov. 17-19 at the University of Alabama in Birmingham.

Co-directors for the course to be held in the ninth floor auditorium of the V.A. Hospital are Drs. John R. Durant and Walter B. Frommeyer, Jr.

The course will emphasize in-depth small group discussions with clinical case material in nine important areas of clinical hematology: paraproteinemias, problems in coagulation, heme synthesis, nutritional hematology, hemolytic anemias, hematologic aspects of immune deficiency diseases, pediatric hematology, leukemia and malignant lymphoma.

Fee for members, Fellows and residents is $80, for nonmembers, $125 and ACP associates, $40. There will be a minimum of 50 and maximum of 60 registrants.

The course carries a credit of 19¾ hours toward the AMA "Physicians Recognition Award."

For further information, write Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

MHA Requests Research Award Applications

Applications are now being accepted for the Mississippi Heart Association Research Awards Program.

The heart association established this program to aid in the development of cardiovascular research, and of future leaders in the broad field of cardiovascular disease and function. The major purpose of the expenditure of funds allocated to research is to support individual investigators and research projects.

Application forms may be requested from the MHA, Box 16063, Jackson 39206. The telephone number is 362-6945.

Deadline for receipt of fellowship and grant-in-aid applications is Nov. 23, 1971, and awards will be announced in May 1972 for the year beginning July 1, 1972.

The doctoral degree or its equivalent is required for all categories.

The association makes the following awards each year: no less than $20.000 to support the UMC Love Memorial Chair of Cardiovascular Research; a $6,000 stipend (plus $500 dependency allowance) to establish research fellowships in departments of Mississippi institutions of higher learning engaged in cardiovascular research; and grants-in-aid from $2,000 to $4,000 to individual investigators to encourage support of basic and clinical research in cardiovascular function or disease or in related fundamental problems.

No less than 12½ per cent of all contributions go to the national program. The awards program is supported entirely by gifts to the annual Heart Fund campaign.

M.D. Art Association Seeks Members

The American Physicians Art Association is a national non-profit organization dedicated to furthering art interests of the medical profession; to broadening the physician's knowledge and appreciation of the past and present; to stimulating physician artists to produce works of art in the fields of painting, sculpture, photography, graphic arts, design and creative crafts; to holding a national annual exhibition of physicians' art works; and to stimulating regional art exhibitions of physicians' works at local, state and specialty meetings.

An art exhibit is held annually in conjunction with the annual meeting of the American Medical Association. The APAA has a membership which extends across the entire United States, Canada and Latin America. Every state in the Union is represented through a regional director. The APAA plans to establish a central photographic archive of its members' art works to be used for year round press and magazine publicity in the physicians' hometowns as well as nationally.

A physician does not necessarily have to be currently engaged in any art activity to become a member. The organization also welcomes the support of anyone interested in furthering physicians' art in America as it is totally supported by the members and friends of the APAA.

The types of membership are: Life Sponsor Membership, $200.00; Sponsor Membership, $30.00; Regular Membership, $15.00; and Associate Membership, $5.00.

For further information, please contact the president of APAA, Dr. A. M. Gottlieb, 3801 Miranda Avenue, Palo Alto, Calif. 94304.

Lilly Introduces Capastat® Sulfate

Capastat® Sulfate (capreomycin sulfate, Lilly), an intramuscular antibiotic preparation for the treatment of pulmonary tuberculosis, is being introduced by Eli Lilly and Company.

Capastat, which is to be used in conjunction with other appropriate antituberculous agents, is indicated in pulmonary infections caused by susceptible strains of *Mycobacterium tuberculosis*. Capastat should be used when the primary agents (isoniazid, aminosalicylic acid, and streptomycin) have been ineffective or cannot be used because of toxicity or in the presence of tubercle bacilli resistant to them.

The use of this antibiotic in patients with renal insufficiency or hearing impairment must be undertaken with great caution, and the risk of additional eighth-nerve impairment or renal injury should be weighed against the benefits to be derived from therapy.

Since other injectable antituberculous agents, such as streptomycin and viomycin, also have similar and sometimes irreversible toxic effects, particularly on eighth-cranial-nerve and renal function, simultaneous administration of these agents with Capastat is not recommended.

Use with nonantituberculous drugs, such as polymyxin, colistin sulfate, gentamicin, kanamycin, and neomycin, which have ototoxic or nephrotoxic potential, should be undertaken only with great caution. Hearing measurement tests should be performed prior to, and at regular intervals during, therapy with Capastat. The safety of the use of Capastat in pregnancy and in infants and children has not been established.

Capastat Sulfate is a polypeptide antibiotic isolated from *Streptomyces capreolus*. It is a complex of four microbiologically active components that have been characterized in part; however, complete structural determination of all the components has not been established.

Nephrotoxicity is the most frequent adverse reaction noted in clinical trials to date. In 36 per cent of 722 patients treated with Capastat, elevation of blood-urea-nitrogen levels above 20 mg./100 ml. and of nonprotein-nitrogen levels above 35 mg./100 ml. has been observed. In many instances there was also depression of phenolsulfonphthalein excretion and abnormal urine sediment. Subclinical hearing loss was noted in approximately 11 per cent of patients being treated with the drug.

Frequent cross-resistance occurs between Capastat and viomycin. Varying degrees of cross-resistance have been reported between the drug and kanamycin and neomycin. No cross-resistance has been observed between Capastat and isoniazid, aminosalicylic acid, cycloserine, streptomycin, ethionamide, or ethambutol.

Capastat Sulfate should be dissolved in 2 ml. of Sodium Chloride injection or sterile water for injection. Two or three minutes should be allowed for complete solution. After reconstitution, solutions may be stored for 48 hours at room temperature and up to 14 days under refrigeration.

The antibiotic should be given by deep intramuscular injection into a large muscle mass, since superficial injections may be associated with increased pain and the development of sterile abscesses.

The usual dose of Capastat is 1 Gm. daily (not to exceed 20 mg./Kg. per day) given intramuscularly for 60 to 120 days. This should be followed by 1 Gm. intramuscularly two or three times weekly until the conclusion of therapy (usually 18 to 24 months). Capastat Sulfate, equivalent to 1 Gm., is supplied in 5-ml.-size rubber-stoppered ampoules (No. 718).

Berkeley Announces MPH Degree Programs

The Maternal and Child Health Program of the University of California School of Public Health at Berkeley announces postgraduate courses of instruction for pediatricians, obstetricians, and other physicians interested in receiving training in the field of maternal and child health. These programs all lead to the degree of Master of Public Health. Tax-exempt Fellowships are available, consisting of support for the trainee and his dependents, tuition and fees.

Program areas available at the present time include nine-month programs in Maternal anl Child Health, Health of School-Age Children and Youth, and Maternal Health and Family Planning. Twenty-one month programs in Care of Handicapped Children, Comprehensive Health Care and Perinatology are available. Fellowships are available for these programs also.

Applications are now being accepted for the group entering Sept. 1972. For information, write to Dr. Helen M. Wallace, School of Public Health, University of California, Berkeley, Calif. 94720.

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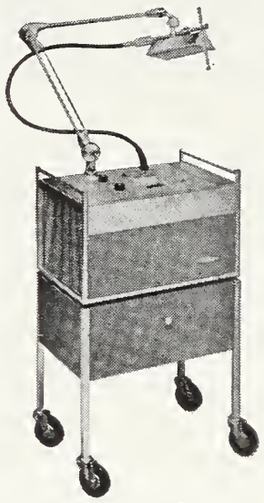
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IN CONCLUSION

The fuss over cyclamates has erupted again in Washington, this time over a bill before Congress to indemnify losses sustained when food industry was caught off balance by government-imposed ban. Hassle came at hearings on bill, generally supported by industry and administration but opposed by consumer advocates. Estimates of loss in manufacturing, processing, labeling, packaging and marketing as result of cyclamate ban run as high as $600 million.

Auto fatalities claim half of teenagers and young adults who die annually in U.S. The National Transportation Safety Board reports that young Americans age 14 through 24 constitute 33 per cent of the 56,400 auto accident deaths each year. But this age group consists of only 21 per cent of licensed drivers, illustrating extremely high accident rate. NTSB recommends driver tests for competency, two-year probationary license to drive, and periodic re-examination.

Private medical clinics are subject to the Fair Labor Standards Act and must pay minimum and applicable overtime wages. Ruling came in case styled Shultz v. Nalle Clinic 444 F.2d 17 (C.A.4, May 18, 1971 when Labor Department sued to enjoin group to comply with act. Court held that a medical clinic is not a retail establishment, that no exemption from law may thereby be sought, and that it was organized for a common business purpose, meaning the practice of medicine.

Credit card insurance covering losses sustained from unauthorized use of stolen cards has become academic under provision of a 1971 law. Limit of liability upon card holder is $50 per card unless limitation is explained on card and means of identifying authorized holder is included. Companies issuing credit cards have until Jan. 25, 1972, to comply but may invoke $50 liability limit by notifying holders of old cards and sending stamped envelope for loss reporting.

A safer Christmas season for small fry is being encouraged by Food and Drug Administration with crackdown on dangerous toys. Recalls are being issued on toys with toxicity, sharp surfaces, and notable flamability. Throughout year, State Board of Health has also issued warnings in interest of child safety. Actions affect only small percentage of toy market, since vast majority of American manufacturers exercise care and caution on safety of products sold.

Volume XII
Number 12
December 1971



JOURNAL of the Mississippi
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THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is owned and published by the Mississippi State Medical Association, founded 1856. Editorial, executive, and business offices, 735 Riverside Drive, Jackson, Mississippi 39216; office of publication, 1201-5 Bluff Street, Fulton, Missouri 65251. Subscription rate, $7.50 per annum; $1 per copy, as available. Advertising rates furnished on request. Second-class postage paid at the post office at Fulton, Missouri.

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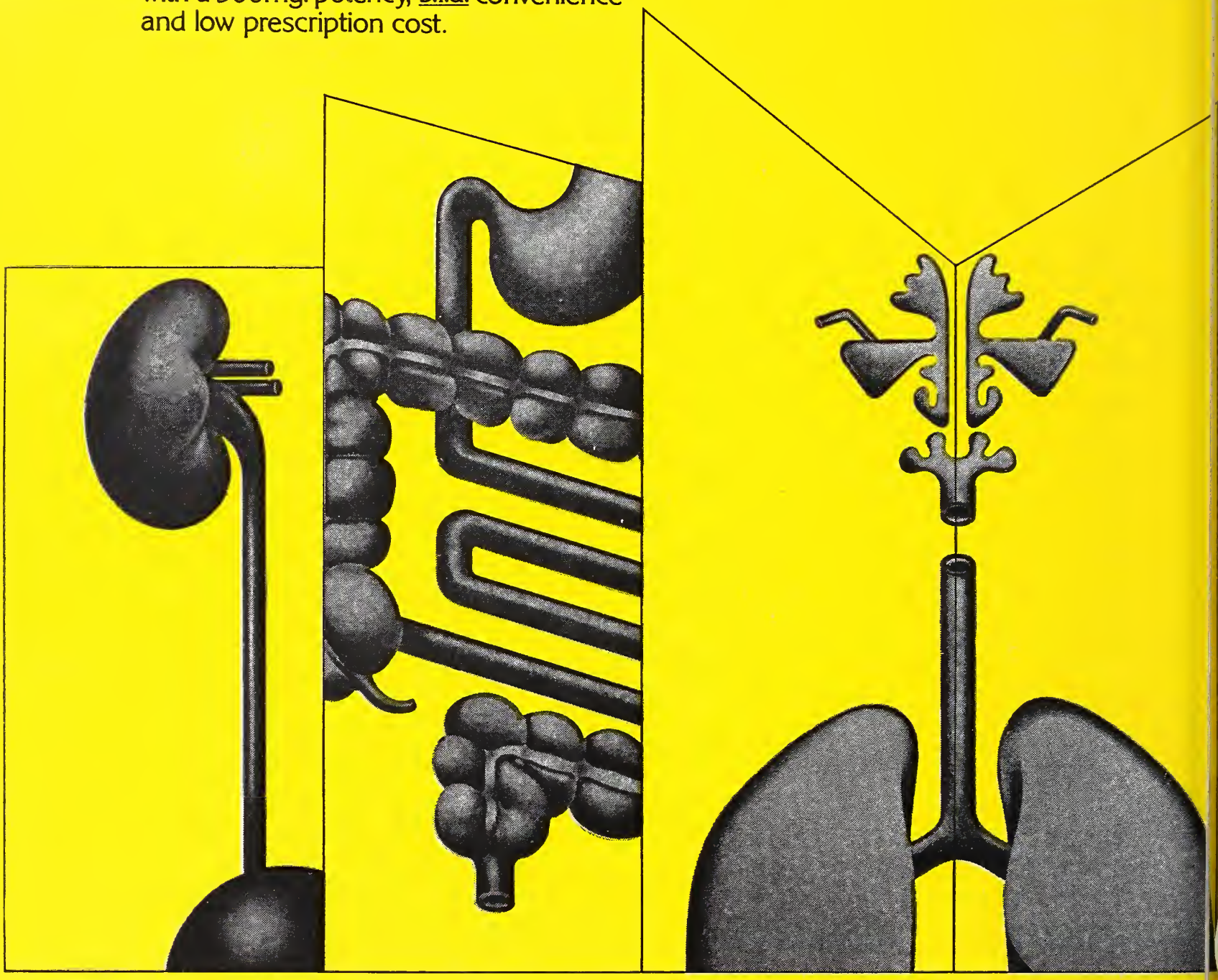
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Precautions: Mycotic or bacterial superinfection may occur. Cases of gonorrhea with a suspected primary lesion of syphilis should have darkfield examinations before receiving treatment. In all other cases where concomitant syphilis is suspected, monthly serological tests should be performed for at least 4 months.

Plasma prothrombin levels may be depressed, patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage. In long-term therapy, periodic laboratory evaluation of hematopoietic, renal and hepatic organ systems should be performed.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. Infants may develop increased intracranial pressure with bulging fontanels. Hemolytic anemia, thrombocytopenia, neutropenia, and eosinophilia hav been reported.

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New Jersey to Get AAP Chapter Award

The New Jersey Chapter of the American Academy of Pediatrics has been selected recipient of the 1971 AAP State Chapter Award. Dr. William Farley, Nutley, is the Chapter chairman.

The award, presented during the Academy's annual meeting on Oct. 20, consists of a plaque and $2,500 provided through a grant from Wyeth Laboratories of Philadelphia, Pa.

The New Jersey Chapter was honored for its wide-range programs including active liaison with key legislators to implement necessary child health care programs throughout the state, a maternal and child health center for lower income and welfare families in Newark, and postgraduate educational programs for hospitals in New Jersey with no pediatric residency programs.

The Chapter, through its Executive Council, played a vital role in securing passage of legislation authorizing a child's own physician to conduct the physical examination necessary for a child to participate in school activities in the state. Prior to passage of this legislation, the school physician was the only physician authorized to conduct such examinations.

The Chapter also worked with legislators to secure passage of legislation requiring new homes in New Jersey to be constructed with doors containing safety plate glass. (This law further recommends—not mandatory—that existing homes have safety plate glass installed in doors.)

The Chapter was further instrumental in the passage of legislation calling for safety regulations for school buses such as automotive safety restraints, emergency exits, rules and regulations regarding behavior on buses, regular inspection of equipment, and periodic monitoring of a bus driver's ability to handle the vehicle.

In another outstanding program, New Jersey has established a full-time maternal and child health center for lower income and welfare families in Newark. Designated the Lyons Maternal and Child Health Center, the project is staffed by several AAP Fellows and other medical personnel, each working voluntarily three to four hours a week.

The Center provides such comprehensive care services as examination and care of newborn, infant immunizations, dental care and treatment, allergy care, emergency care for injuries and accidents, and specialist consultations.

The New Jersey Chapter sponsors a unique program of postgraduate educational opportunities for hospitals throughout the state, particularly those with no pediatric residency programs.

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NEWSLETTER

December 1971

ar Doctor:

esident Nixon has named Mississippi's Dr. William E. Lotterhos Jackson to Phase II organization for economic stabilization. . Lotterhos will serve on 21-member Committee on Health Services Industry, advising Treasury Secretary Connolly's Cost of ving Council. Chairman of the committee is Mrs. Barbara Dunn, mmissioner of Connecticut Department of Consumer Protection.

Only four physicians will serve on advisory body which has representation from entire health care team. Members include those from hospitals, nursing, dentistry, insurance, Blue plans, universities, pharmaceutical manufacturing, labor, state government, and consumers.

jor reorganization of AMA Field Service has as purpose economy d new direction, according to Chicago headquarters. Memphis office which has served five states, including Mississippi, will be osed. Leon J. Swatzell, Field Service Representative well known Mississippi MDs, will be transferred to Atlanta. New mission phasizes legislation, political action, and membership.

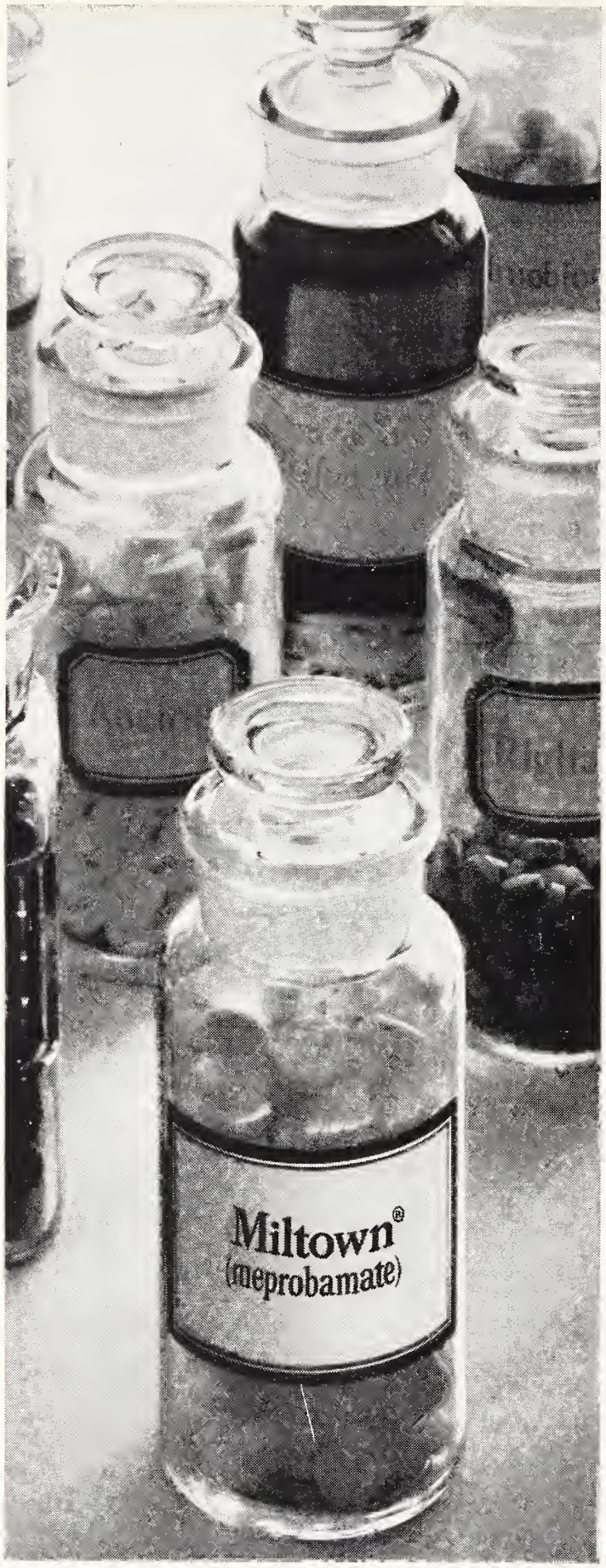
e association's largest component, Central Medical Society, has ted moratorium on prescribing amphetamines. Exceptions are in ses of narcolepsy, hyperkinesis, and certain psychiatric disorrs. Society has also organized team of physician speakers for blic education against drug abuse. Program is receiving wide blic acceptance and commendation in greater Jackson area.

erican Hospital Association has dumped its Ameriplan proposal for tional health insurance. Scheme would have created "health service corporations" financed by state and federal taxes and compulsory ntributions. Signal of abandonment came at the recent AHA convention where measure was narrowly passed after sharp debate. AHA supporting "diverse approaches" to financing of health care.

sponse to 1972 consolidated dues billing has been excellent, and mbers are reminded to pay this month for tax deduction purposes. lling permits convenience of one check to cover all dues, MPAC d AMPAC memberships, wife's Auxiliary dues, and AMA-ERF gift. l items billed except local and state dues are voluntary, but plus per cent are choosing to pay 1972 AMA dues.

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AAFPRS Sponsors January Workshop

The American Academy of Facial Plastic and Reconstructive Surgery, Inc. will sponsor a workshop on Concepts of Soft Tissue Surgery on Jan. 23-29, 1972, at Mercy Hospital, Pittsburgh.

The workshop is designed to cover the fundamentals of soft tissue surgery in the region of the head and neck. Illustrated lectures, television tapes, operative demonstrations and laboratory exercises and movies form the basic didactic material. Participants will be encouraged to present problem cases for discussion by the faculty.

There will be a registration fee of $400.

For more information, contact Dr. John T. Dickinson, G-2 M.D. Building, 1501 Locust Street, Pittsburgh, Pa. 15219.

New Surgery Journal Is Published

Contemporary Surgery, a new journal dedicated to continuing education in surgery and the cross-fertilization of ideas between specialties, will begin publication in Jan.

An outstanding editorial board composed of leading surgeons in the principal specialties will guide the editorial direction of the new journal, published by McGraw-Hill Publications, publishers of *Medical World News* and other journals.

Dr. John G. Bellows is the Chief Editor and Dr. Morris Fishbein is Editorial Consultant.

The Editorial Board includes Drs. Herbert L. Abrams, Thomas Baffes, Michael DeBakey, Rainer Engel, Andrew Gage, Thomas Green, David Hsia, Leon Jacobson, Francis Lederer, George E. Moore, Langdon Parsons, Max Sadove, Harold G. Scheie, William W. Scott, M. Eugene Tardy, and Marshall R. Urist.

Contemporary Surgery was founded to fill the need for a meeting point on the common grounds of surgery. The objective of the journal is to help keep surgeons up to date on the latest thinking in surgery and medicine. The articles are intended to help surgeons to constantly evaluate their ideas, to reorient their thinking, and to expand their views.

The editors welcome the assistance and participation of surgeons and of all those interested in the advancement of surgery. Authors may obtain editorial guidelines from the Chief Editor, Dr. John Bellows, 30 North Michigan Avenue, Chicago, Ill. 60602.

DATELINE

ilbur Mills Lauds eer Review

Washington - Rep. Wilbur Mills (D.,Ark.), powerful chairman of the Ways and Means Committee, has warmly praised medical society-ponsored peer review. Chairman Mills said during hearings on ational health insurance that peer review committees "do a wonerful service," stating that he sat in on Arkansas peer review ommittee meeting at Little Rock. He said it would be a great ervice if all Congressmen could see committees in action.

---

llini Foundation ontracts Medicaid

Chicago - The Illinois Foundation for Medical Care and the state have concluded a contract for IFMC to certify every Medicaid hospital admission and review services rendered. Program, called HASP for ospital Admission and Surveillance Program, is expected to save 12 million annually for foundering Illinois Medicaid. State will ay foundation $18 per admission for services. Gov. Ogilvie has ommended program and state medical society's foundation.

DA, BNDD Endorse ethadone Program

Washington - The Food and Drug Administration has endorsed use of methadone for maintenance of heroin addicts, reversing position previously held. Joining FDA was Bureau of Narcotics and Dangerous Drugs. ince 1963, methadone maintenance programs have been licensed as investigational" but have grown in number and controversy. FDA ction will probably culminate in license of methadone as a "new rug," Capitol Hill observers say.

SIM Joins CAP n Lab Program

Chicago - The laboratory quality assurance program originated by the College of American Pathologists has been joined by American Society f Internal Medicine as co-sponsor. It will henceforth be known s the Proficiency Evaluation Program (PEP). Cost is $80 per year, nd subscribers submit test results four times annually in kit amples provided by program. CAP has also purchased major computer enter in Michigan to process tests.

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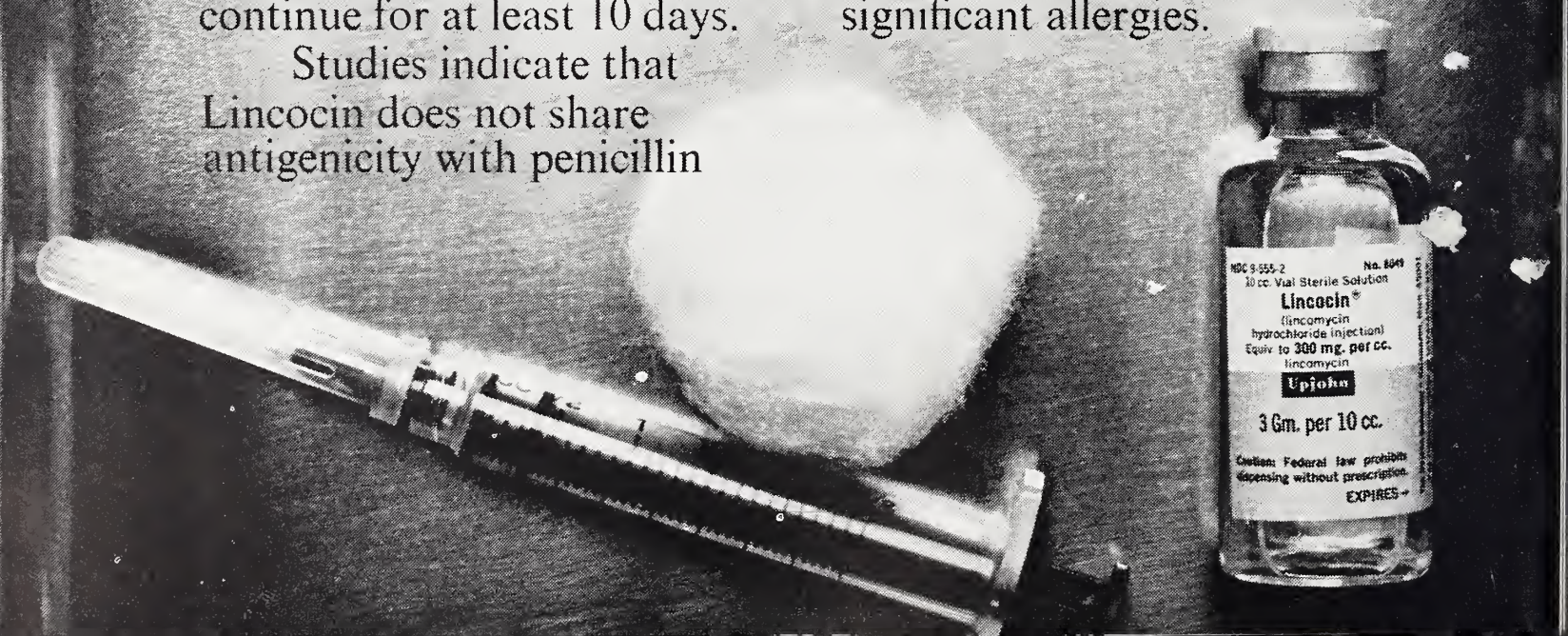
enate Bill eeks Ethics Body

Washington - Little chance is given for passage of measure to create national commission to assess moral and ethical implications in health ervices including abortion, contraceptives, and genetic engineering. ut up by Sen. Walter Mondale (D.,Minn.), measure was opposed by ixon administration who says that ethical and moral questions are lready being scrutinized by NIH and private groups. Deliberations y AMA and Judicial Council pronouncements were cited.

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Studies indicate that Lincocin does not share antigenicity with penicillin compounds. However, hypersensitivity reactions such as angioneurotic edema, serum sickness and anaphylaxis have been reported, some of these in patients known to be sensitive to penicillin. As with any antibiotic, Lincocin (lincomycin hydrochloride, Upjohn) should be used cautiously in patients with histories of asthma or other significant allergies.



Cryosurgery Meeting Is Scheduled

The 1972 combined meeting of the Society for Cryosurgery and the American Society of Contemporary Medicine and Surgery will be held Feb. 28-March 3, 1972, at the Diplomat Hotel, Hollywood, Fla.

The theme of the meeting is "Continuing Education for Contemporary Medicine and Surgery." Enrollees will receive certificates of participation in continuing education.

Lectures on the latest advances in dermatology, gynecology, ophthalmology, otolaryngology, and urology will be given by permanent faculty and noted guest speakers. The program will include a special symposium on cancer conducted by world renowned specialists.

For information, write: Dr. John Bellows, 30 North Michigan Ave., Chicago, Ill. 60602.

Community Screening Guidelines Published

A new manual for service clubs interested in community disease screening programs has been published by the Disease Detection Information Bureau of Chicago, Ill.

Called *Guidelines for Service Clubs in Community Disease Screening Programs,* the manual offers practical how-to-do-it information on the basics of disease screening. It was developed at the request of service organization representatives who participated in the Conference on the Role of Community Organizations in Disease Screening Programs.

The Conference was conducted by the Disease Detection Information Bureau and sponsored by Ames Company, Division Miles Laboratories, Inc., Elkhart, Ind.

Included in the *Guidelines* is information on the nature of disease screening, why community screening programs are needed and which diseases can be detected through screening. Service clubs can learn how to determine the kind of screening program to conduct, plan the program, gain the participation of the rest of the community and promote the program.

Names and addresses of national health organizations interested in disease screening are listed in the *Guidelines.*

Service organizations may obtain a copy of the *Guidelines* (no charge) by writing on the club's letterhead to the Disease Detection Information Bureau, 3553 West Peterson Avenue, Chicago, Ill. 60645.

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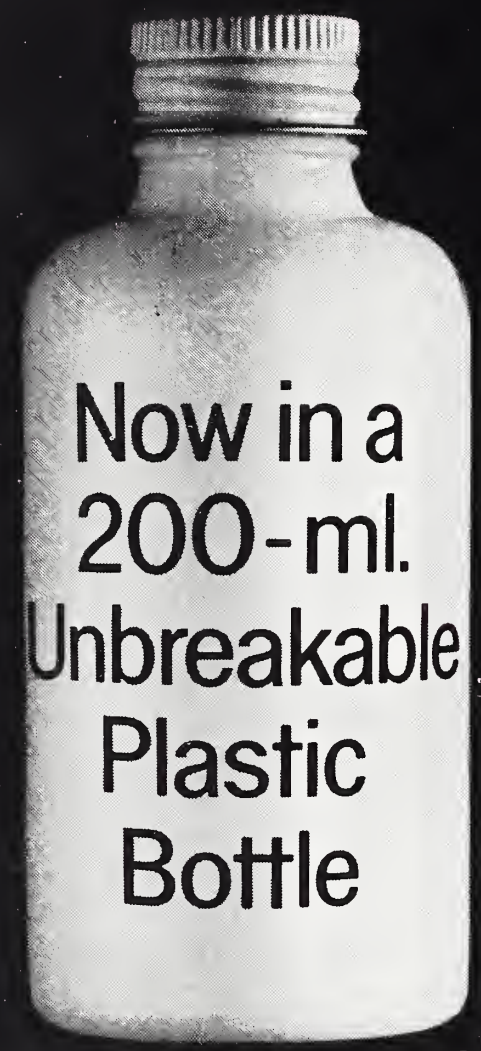
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
December 1971, Vol. XII, No. 12

ORIGINAL PAPERS

The Treatment of Malignant Tumors in Childhood

JUDSON G. RANDOLPH, M.D.
Washington, D. C.

Because of the peculiar biological nature of malignant tumors in childhood and their relationship to embryology, a major breakthrough in cancer control seems closest in cancer of childhood. The author discusses recent advances in the treatment of these tumors and gives the results of a study on neuroblastoma, Wilm's tumor, rhabdomyosarcoma, and primary hepatic malignancy done at the Children's Hospital of Washington, D. C., from 1965-70.

PERHAPS NO FIELD in medicine today exceeds the opportunity for major breakthroughs than is to be found in the study of malignant disease in childhood. Because of the peculiar biological nature of these tumors, their relationship to embryology and the certain specifics of knowledge that has been gained in the past 20 years, the major secrets of the etiology and control of cancer seem closest to the surface in cancer of childhood.

Two decades ago the field of cancer chemotherapy was opened up by Dr. Farber's attack on leukemia using folic acid derivatives. Subsequently, the story of actinomycin-D and its specificity in the control of Wilm's tumor has been well documented. More recently, Bill and Hellstroms[1] in Seattle have demonstrated antibodies against neuroblastoma in the serum of patients suffering with this disease and in the mothers of these patients; Thus, an immune protective mechanism against this tumor would seem a strong possibility.

It now remains to be demonstrated that the immune system can be directed against neuroblastoma, affording another weapon against its devastating effects. In the recent past rhabdomyosarcoma has shown that it, too, will respond favorably in certain circumstances to chemotherapy attack, when allied with x-ray therapy and proper surgery.

Over the past 10 years there has been a growing interest in tumors of the liver in childhood. These are rare, and as yet, chemotherapy has not been found which is effective in the control of these tumors. However, extended surgery now makes it possible to save some children from what was once thought a uniformly fatal disease.

Such areas of progress render real the hope that childhood malignancy can be brought to heel. Cancer annually kills more children in the United States than any other disease; only accidents kill more children in this country. An increasingly optimistic view seems warranted as one reviews the survival rates in treating major types of solid tumors over the past 20 years. In dealing with childhood cancer, early detection remains an all

Presented before the Section on Surgery, Mississippi State Medical Association, Biloxi, May 4, 1971.
From the Department of Surgery, Children's Hospital of the District of Columbia.

important factor in children, as in adults. Surprisingly, younger children appear better able to survive than older ones. This observation throws added responsibility on the pediatrician and physician to be on the alert for the even rarer forms of childhood cancer.

The following study is derived from a statistical analysis of neuroblastoma, Wilm's tumor, rhabdomyosarcoma, and primary hepatic malignancy seen at the Children's Hospital of Washington, D. C., from 1965 through 1970 (see Table 1).

NEUROBLASTOMA

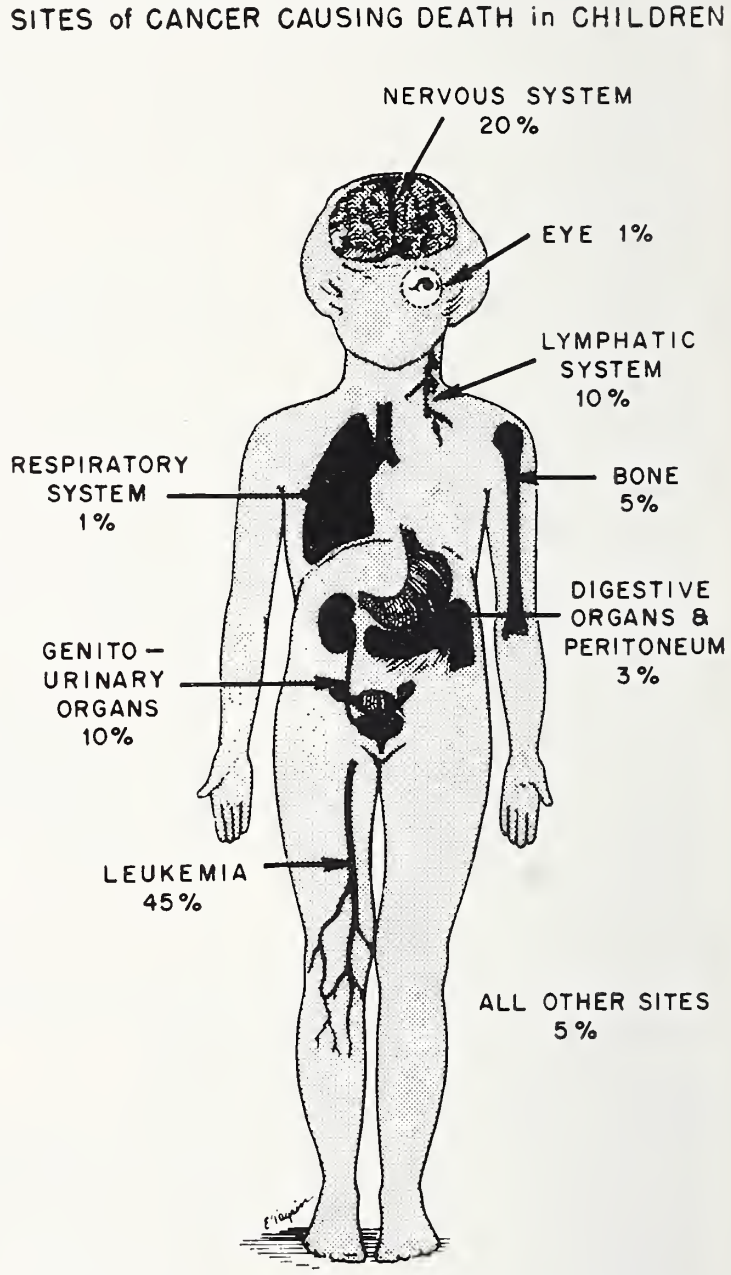
The neuroblastoma arises in the sympathetic nervous system and adrenal medulla. It is a rapidly growing neoplasm showing various degrees of cellular differentiation and maturation. A ganglioneuroma is histologically mature and is considered a benign derivative of neuroblastoma. This tumor is seen in infants and young children. The peak incidence is between one and two years of age. The ages of our patients ranged from 3 weeks to 9 years with the mean of 2.3 years. There was no sex difference in our cases or in other reported series. In our series 22 of 28 children had primary tumors located in the abdomen. The other sites of the primary tumors included the chest (3) and the neck (1); in 2 infants with disseminated tumor in the liver and subcutaneous tissues, the primary site could not be ascertained. Two-thirds of reported cases and 24 of 28 patients in our series had metastasis at the time of diagnosis. The initial diagnostic studies to determine the site and extent of disease include intravenous pyelogram, inferior venacavagram, bone survey, bone marrow examination, and 24-hour urinary determination for VMA and other catecholamines.

TABLE 1

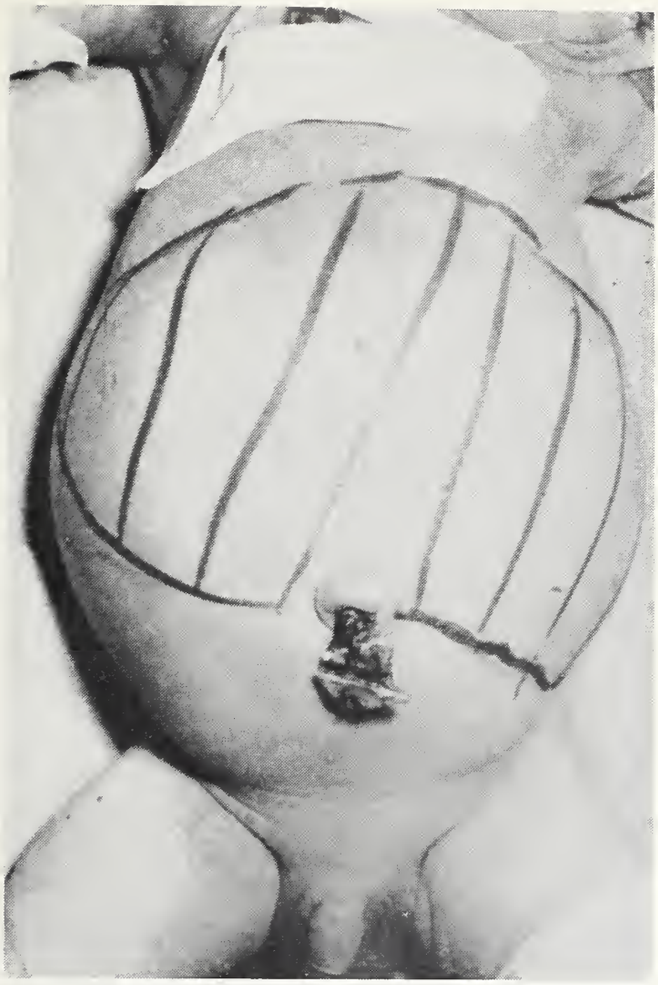
NUMBER OF PATIENTS WITH COMMON MALIGNANT TUMORS SEEN AT THE CHILDREN'S HOSPITAL OF D. C. (1965-1969)

Year	*Wilm's Tumor*	*Neuroblastoma*	*Rhabdomyosarcoma*	*Hepatoma*
1965	5	6	2	1
1966	3	4	2	2
1967	6	5	3	1
1968	3	4	1	–
1969	4	9	–	2
Totals	21	28	8	6

Complete surgical removal should be attained whenever possible. Removal of tumor bulk is desirable even if total removal is impossible; if this means spilling tumor, spooning it out or removing some with the sucker, it is still a reasonable approach. Radiation experts and chemotherapists are agreed that their treatment of the remaining tumor is more effective if the large bulk has been removed. If immunology factors play a role, then removal of the bulk of the tumor makes sense. It is not reasonable to threaten the life of the patient with extended surgery for abdominal neuroblastoma. Rather if it is clearly not resectable, one should fall back and resort to x-ray therapy. A second-look procedure two to six months following x-ray therapy may allow complete excision.



1. Incidence of childhood malignancy. Reprinted from Surgery, a Concise Guide to Clinical Practice, Chapter 23, Pediatric Surgery, Randolph, J. G.; edited by Nardi and Zuidema, Little, Brown and Company, 1964.



2. Neuroblastoma with hepatic involvement in a four month old baby. This infant recovered completely, as often occurs in this age group with neuroblastoma.



3. Venacavagram showing complete obstruction. Note filling of hemiazygos system. This study is helpful in many children with abdominal tumors.

Surgery for primary thoracic neuroblastoma should be aggressive and may need to involve portions of the chest wall or intercostal muscle. Biopsy of neuroblastoma (unlike Wilm's) is acceptable. It is important to note that babies under one year of age seem to do well irrespective of the extent of their disease. It is in this group of patients that one may find skin lesions and multiple liver lesions and even if they are grouped in a certain area of the liver, excision is unnecessary.

Postoperative radiotherapy to the tumor bed is supplemented by chemotherapy consisting of Cytoxan and vincristine. In our patients whose primary tumor could not be completely removed, radiotherapy and/or chemotherapy were employed and a second attempt was usually made to achieve complete surgical removal.

The prognosis is primarily related to the age of the patient. Although children less than 12 months of age frequently have disseminated disease and massive involvement of the liver, subcutaneous tissue or bone marrow, prognosis in this age group is most favorable and 90 per cent are cured irrespective of therapy. Our results are identical with reported series in the literature (see Table 2). The 17 patients who died had metastasis at the time of diagnosis, and the length of survival ranged from 1 to 24 months with a mean of 8.3 months. The site of the primary tumor has some bearing on survival. Neuroblastoma appearing in the neck or chest carries a more favorable prognosis than that originating in the adrenal gland or retroperitoneum.

WILM'S TUMOR

Wilm's tumor or embryoma of the kidney is the most common abdominal tumor in young children. In our series the ages of the children with Wilm's tumor ranged from 6 months to 6½ years with a mean of 3 years. Males and females were equally affected. An abdominal mass in the flank extending well into the abdomen was present in every case. Hematuria was found only rarely.

The tumor is usually encapsulated but may penetrate the capsule to invade the renal vein or vena cava, regional lymph nodes, and/or liver. The lungs are the most common site of distant metastasis. At the time of diagnosis 10 of the 21 patients exhibited a well encapsulated, completely removable tumor. Regional metastasis to either the inferior vena cava, lymph nodes, peritoneum or liver were found in six patients. In two cases the tumors were bilateral. One patient had a ruptured tumor at the time of exploration.

Prior to surgery all patients undergo diagnostic laboratory and radiologic studies including a combined inferior venacavagram and excretory urogram, chest x-ray films, bone surveys, and bone marrow examination for metastatic tumor cells. Although the last mentioned is performed without undue delay, it is not considered an "emergency" procedure.

It is our practice to perform a standard nephrectomy plus removal of the renal pedicle nodes. In the case of extension of the tumor outside of the capsule to contiguous organs, removal of adjacent structures such as (a) wedge resection of liver, (b) liver lobectomy if necessary, (c) vena cava portion for direct extension out the renal vein, (d) adrenal gland if kidney does not separate easily, or (e) en-bloc excision of invaded muscle tissue is carried out. When pulmonary metastases are present x-ray therapy and chemotherapy are first used. With persistence or reappearance of a single nodule following x-ray and chemotherapy, excision is appropriate if there is no evidence of widespread bilateral disease. Resection should be conservative wedge with good

TABLE 2

SURVIVAL OF NEUROBLASTOMA PATIENTS

Categories	*No. of Patients*	*Alive*	*Dead*	*Per Cent Survival*
No metastasis at time of diagnosis	4	4	–	100
Metastasis at time of diagnosis	24	7	17	29
Age at diagnosis 12 mos.	8	6	2	75
Totals	28	11	17	40

margin, *not* lobectomy since pulmonary parenchyma may be at a premium because of metastases and postirradiation changes.

Postoperative treatment includes radiation of the tumor bed as well as one or more courses of actinomycin-D. Current experience would indicate that the prognosis is generally favorable in most young patients with Wilm's tumor. Farber,[4] in a review of the literature, found that up to 89 per cent of patients with localized tumors had a two-year survival and could be considered "cured."

To date 14 of our patients are alive (see Table 3). In this group, eight are alive and have been tumor free for 2 to 5 years and therefore can be considered cured; an additional six patients have been alive for a period of 8 to 24 months with no recurrence of the tumor. Among the long term survivors are included 10 patients who had no demonstrable metastases, three who had local spread, and one who had bilateral tumors. Of the seven patients who died, four had metastasis at the time of diagnosis and lived from 3 to 20 months. One patient who had bilateral tumor lived 28 months.

TABLE 3

SURVIVAL OF WILM'S TUMOR PATIENTS

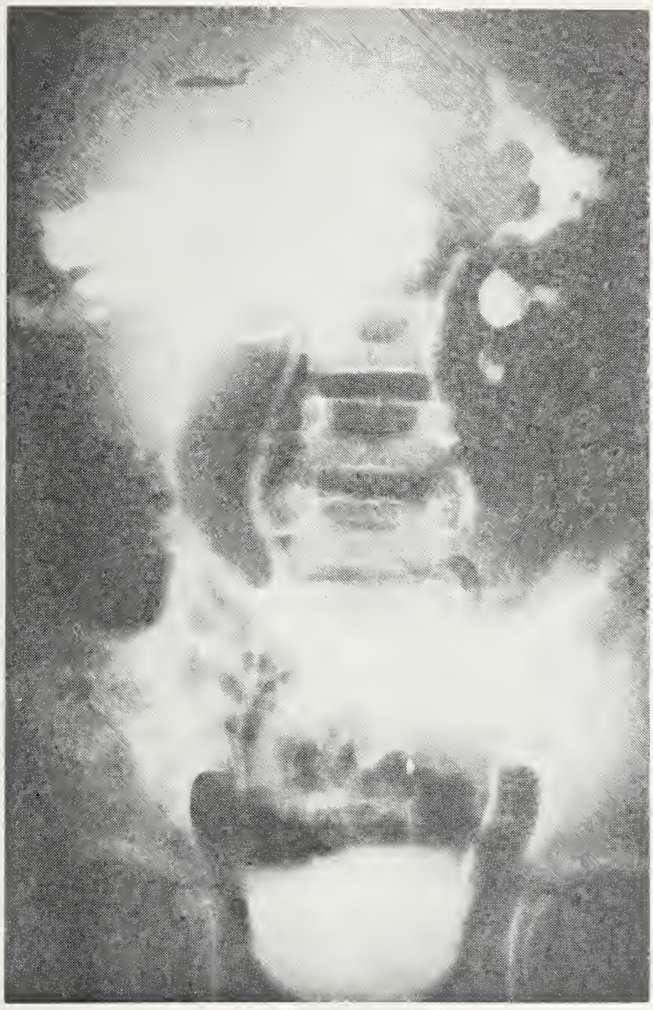
Categories	*No. of Patients*	*Alive*	*Dead*	*Per Cent Survival*
No metastasis at time of diagnosis	12	10	2	83
Metastasis at time of diagnosis	7	3	4	43
Bilateral tumor	2	1	1	50
Totals	21	14	7	67

The prognosis is guarded when the renal vein or inferior vena cava, lymph nodes, or lungs are involved. However, even in these cases, with a combination of surgery, radiotherapy and chemotherapy, two-year survivals and possible cure can be achieved in about half of the patients.

The salutary effect of chemotherapy with actinomycin-D on pulmonary metastasis is well known. Recently it has been shown that vincristine is also effective in controlling pulmonary metastases in patients with Wilm's tumor.

RHABDOMYOSARCOMA

Rhabdomyosarcoma is the most common soft tissue sarcoma in children. It arises from striated muscle and consists of cells possessing the characteristics of those of rhabdomyoblasts. Histologically the pleomorphic and alveolar forms are found in adults while the embryonal or botryoid type is more common in children. Rhabdomyo-



4. Intravenous pyelograms of patient with bilateral Wilm's tumor.

sarcoma usually occurs in children under 10 years of age or in adults between 50 and 70 years of age. This tumor is more often found in males than in females (3:1 in our series).

The origins of the primary tumors in the patients in our series were the upper extremity (2), the lower extremity (1), the pelvic area (2), the nasopharynx (1), the orbit (1), and the mastoid area (1). Metastases to the lymph nodes, lungs, liver, brain or bones occur early. At the time of diagnosis, five of our patients had demonstrable metastases and three had localized tumors. All patients underwent radical surgical removal of the tumor or amputation of the involved limb. Following surgery patients received radiotherapy and chemotherapy with a combination of Cytoxan, vincristine and actinomycin-D.

Great changes in thinking as to appropriate therapy have been taking place in the surgical treatment of rhabdomyosarcomas. It is still a proper concept that a wide local excision should be done. However, no longer is it felt necessary to do amputations for extremity lesions in the muscle. It may be prudent to take a wide section of muscle including some of the underlying periostium and even some of the bone, but amputation is not mandatory.

Interesting new information stemming from the radiotherapists indicates that their therapy can be applied after a wide local extremity excision, sparing the growth centers at the ends of the bone. A less radical surgical and radiotherapy approach to extremity tumors combined with chemotherapy would seem to be an advance in the management of rhabdomyosarcoma. The current favorable results in patients with microscopic residual disease treated with chemotherapy and x-ray seems to justify this approach.

In pelvic rhabdomyosarcoma, certain generalities can be made although each tumor must be evaluated individually. Wide local excision usually means complete pelvic exenteration for vaginal tumors. This is because some tumors which appear grossly to be well confined will show microscopic invasion of adjacent bladder and rectum. Prostate tumors in boys demand wide local excision and in most instances, pelvic exenteration; occasionally it may be possible to spare the rectum, but the same caution regarding microscopic spread exists here.

TABLE 4

SURVIVAL OF RHABDOMYOSARCOMA PATIENTS

Categories	*No. of Patients*	*Alive*	*Dead*	*Per Cent Survival*
No metastasis at time of diagnosis	3	2	1	67
Metastasis at time of diagnosis	5	2	3	40
Totals	8	4	4	50

Because there are three pelvic organs in the girls, it is easier to spare the bladder in posteriorly situated tumors, and to spare the rectum in anteriorly situated tumors. Occasionally some of the genital tract can be spared but generous margins must be insisted upon. Spare one ovary if at all possible. It should be metal clipped for x-ray identification and brought up into the abdomen on its blood supply so that pelvic radiation can be given with the ovary shielded.

The prognosis is related to the location of the primary tumor and the presence of distant metastasis. Rhabdomyosarcomas of the orbit or distal extremities have a better prognosis because

complete removal of the tumor is technically feasible, whereas tumors originating in the nasopharynx or pelvis do not lend themselves to complete surgical excision. The results of our series are shown in Table 4. Four patients were alive from 18 months to 60 months with no evidence of tumor, although two had metastasis at the time of diagnosis. Four patients are dead. Three of these had metastasis at the time of diagnosis and survived for 2 to 10 months.

HEPATOMA

Primary liver tumors produce a large abdominal mass. Anemia, low-grade fever, jaundice, and anorexia may be present. In addition to the routine preoperative studies, a liver function profile, liver scan, and celiac arteriogram may aid in the diagnosis.

Hepatic resection offers the only hope for cure. Technical considerations include meticulous dissection of the portal triad and absolute control of vena caval flow. Postoperative management must focus on clotting abnormalities, hypoglycemia, and hypoalbuminemia, all of which may accompany major hepatic resections.

We have been particularly impressed with the possibility of removing huge tumors from small children if one pays attention to the hepatic architecture. What may at first glance appear to be an inoperable tumor may be confined to the right and middle lobes of the liver so that it can be shaved off the left lobe sparing some bile drainage and arterial supply. Even though the resection margin is close we have been encouraged by long term survival of patients so treated. The remarkable propensity for the liver to regenerate when as much as 80 per cent of its total mass is resected has been an astounding and helpful complement to the postoperative course.

In our series, depicted in Table 5, there have been 14 patients with primary liver tumors. Nine underwent right hepatic lobectomy, two a left lobectomy, two a wedge resection and one a biopsy. It is interesting that six of the seven survivors are in the group undergoing a right hepatic lobe resection.

SUMMARY

Physicians who are involved in the care of children should be alert to the possibility of malignancy in a child with an abdominal mass or a history of prolonged fever, weight loss, bone pain or fatigue. Early detection of cancer in children is especially important since the majority of localized tumors can be eradicated completely.

Basic laboratory and x-ray studies which are routinely employed in patients under evaluation for tumors include bone marrow examination for metastatic tumor cells, bone survey or bone scan for skeletal metastasis, and inferior venacavagram for evidence of obstruction or invasion of the inferior vena cava. Aortogram or selective arteriogram may supplement this workup. Selective radio-isotope scan of the brain, lungs, liver and bones are also helpful for the detection of primary or metastatic lesions in these organs.

At our institution a tumor team consisting of a pediatrician, surgeon, radiologist, chemotherapist and pathologist has been established. Any patient with a malignant lesion is presented to this group where decisions concerning the management of the lesion are reached in concert.

The team effort in the management of pediatric malignant disease has contributed to the marked improvement in the survival statistics of children with cancer. This encouraging progress demands

TABLE 5

PRIMARY LIVER TUMORS*

Pathologic Disease	*Number of Patients*	*Surgical Treatment*			
		BIOPSY	WEDGE RESECTION	RT. HEPATIC LOBECTOMY	LT. HEPATIC LOBECTOMY
Hepatoblastoma	9 (5)	1	2 (1)	6 (4)	1
Hepatic carcinoma	2 (0)	1			1
Embryonal sarcoma	1 (1)			1 (1)	
Hamartoma	2 (1)			2 (1)	
Total	14 (7)	2	2 (1)	9 (6)	2

( ) = Survivors
* 1964–1971 inclusive



5. Right hepatic lobectomy for hepatoblastoma in a 22 month old. Left lobe remains. Clamp identifies diaphragm which has been split to improve exposure of hepatic veins.

a constant vigilance by the practitioner and provides hope for a much more optimistic outlook in the future. ★★★

Children's Hospital of the D. C. (20016)

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AN EYE FOR AN EYE

A delegation visiting Tel Aviv called on Prime Minister Golda Meier, the brilliant, U. S.-educated head of the Israeli state. One member of the delegation, a Roman Catholic prelate who was especially dedicated to peace in the Middle East, made a proposal:

"Madam Prime Minister," he said, "why don't you and the Arabs get together and settle your differences in a Christian manner?"

Regarding him coldly for a moment, the noted stateswoman replied: "That is precisely what we are trying to avoid, Monsignor, particularly after observing the negotiations between Catholics and Protestants in Northern Ireland."

A Review of the Mississippi Medicaid Program

ALTON B. COBB, M.D.
Jackson, Mississippi

Medicaid, a Federal-state program for purchasing health care services for the needy, is administered in this state by the Mississippi Medicaid Commission. Dr. Alton B. Cobb, program director, gives a review of eligibility, services, administration, expenditures and utilization during fiscal year 1971.

MEDICAID IS A Federal-state program for purchasing health care services for the needy. Federal statutory authority for Medicaid is Title XIX of the Social Security Act and in Mississippi legal authority is the Medical Assistance Act as enacted by the Extraordinary Session of the Mississippi Legislature in late 1969.

At the Federal level, Medicaid is administered by the Social and Rehabilitation Service agency of the Department of Health, Education, and Welfare. In Mississippi, administration is the responsibility of the Mississippi Medicaid Commission, which is composed of four legislators and three lay members appointed by the Governor. This is a unique arrangement for administering Medicaid among the several states. As of this date, all states have Medicaid programs with the exceptions of Arizona and Alaska.

Funds for Medicaid Program services are provided from Federal and state tax revenues. Each state is assigned a Federal matching percentage under a formula set out in Title 19; the formula relates the average per capita income of the state to that of the other states. Federal matching varies from a minimum of 50 per cent to a maximum of 83 per cent. Mississippi continues to qualify for the maximum Federal matching of 83 per cent.

Individual eligibility determination for Medicaid is required by Federal and state law to be a responsibility of Public Wefare. States must cover all categorically needy individuals (persons qualifying for money assistance) and states may cover certain other groups of needy citizens who do not qualify for money assistance but are needy and otherwise dependent. In Mississippi, as in the other southern states, eligibility is restricted to the categorically needy and a relatively small number of additional needy persons.

Read before the Section on Preventive Medicine, 103rd Annual Session, Mississippi State Medical Association, Biloxi, May 5, 1971.

Director, Mississippi Medicaid Commission.

Title XIX requires states to purchase as a minimum these health services: physician, hospital, skilled nursing home, laboratory, screening and diagnostic, home health, and ambulance. Title XIX permits states to include in their programs a number of optional health services such as: drugs, eyeglasses, tuberculosis and mental hospital services, and dental care.

There were 199,050 persons eligible for Medicaid services at the beginning of fiscal year 1971, and 217,555 persons eligible at the close of the period. The number of eligibles in the program categories and the annual rate of increase are shown in Table 1. The Program categories are Old Age Assistance (OAA), Aid to needy Blind (AB), Aid to the Permanently and Totally Disabled (APTD), and Aid to Families with Dependent Children (AFDC).

The following services are authorized for reimbursement under the Mississippi Medicaid Program: physician, hospital, skilled nursing home, laboratory, screening and diagnostic, home health, ambulance, drugs, dental care (extractions), eyeglasses (after eye surgery), tuberculosis hospital, and Medicare, Part B Buy-In. (This is not a service, but makes possible Medicaie payment for covered services under Part B.)

The Medicaid Commission has a fiscal agent contract with the Mississippi Hospital and Medical Service (Blue Cross-Blue Shield). This is

an annual, cost reimbursement contract. This contract is reviewed by HEW and expenditures under it have been audited by a national audit firm for the Commission.

In Mississippi, three agencies or organizations are involved in the administration of Medicaid. These three are: The Welfare Department, Blue Cross-Blue Shield, and the Medicaid Commission.

Now, with the foregoing as a background, let us look at expenditures under the Mississippi Medicaid Program. For the purpose of this report, the period July 1, 1970-June 30, 1971, will be used.

During the first full fiscal year of activity of the Mississippi Medicaid Program a total of $38,126,339 was expended for services and administration of the program.

Regulations of Title XIX of the Social Security Act, the Federal Medicaid legislation, provide that Mississippi shall receive Federal funds for 83 per cent of the cost of medical services, 75 per cent of the cost of professional staffing and related administrative costs, and 50 per cent of other administrative costs. This resulted in 81.9 per cent of Medicaid expenditures being Federal funds in FY 1971, as shown in Figure 1. Of the expenditures of $38,126,339, Federal funds totaled $31,240,051 or 81.9 per cent of expenditures, while 18.1 per cent or $6,886,288 was state money.

TABLE 1

NUMBER OF PERSONS ELIGIBLE FOR MEDICAID JULY 1, 1970 AND JUNE 30, 1971, WITH ANNUAL RATE OF INCREASE BY PROGRAM CATEGORY

Program Category	*Number of Eligibles July 1, 1970*	*Number of Eligibles June 30, 1971*	*Annual Rate of Increase (Per Cent)*
Total	199,050	217,555	9.3
OAA	74,943	79,560	6.1
AB	2,126	2,193	3.1
APTD	22,030	25,665	16.5
AFDC	99,951	110,137	10.2

Expenditures for administration of the Medicaid Program totaled $1,279,505, or 3.4 per cent of the cost of the program. This index to program administration efficiency compares very favorably with other states having similar Medicaid programs. The actual administrative expense was considerably less than the amount budgeted for this purpose and accounted for most of the unexpended state funds. This is due in large part to a systematized, computerized claims payment and information system, established by a consultant management team on contract with the Mississippi Medicaid Commission and its fiscal agent, Mississippi Hospital and Medical Service (Blue Cross-Blue Shield).

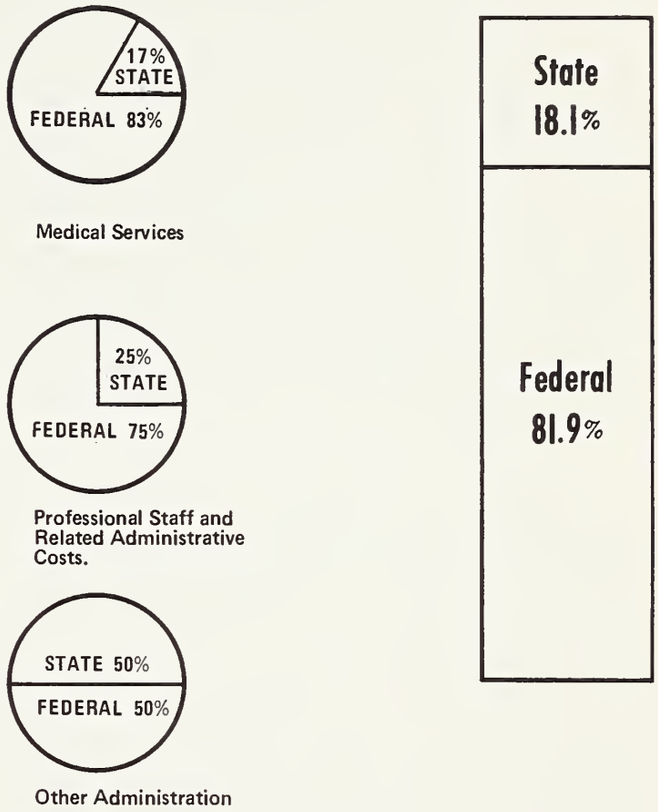


Figure 1. Source of funds by type of expense and percentage distribution of state and Federal funds for fiscal year 1971.

A total of $41,175,087 was budgeted for the Medicaid Program for FY 1971, and of this amount, $38,126,339 was expended. Of the unspent balance, $1,198,970 was state funds and this amount reverted to the State Treasury after the close of the fiscal year. The major portion of these unused state funds had been appropriated for administrative expense.

During fiscal year 1971, $36,996,162 was spent for medical services for Medicaid eligibles, with an average of $177.60 spent per eligible. Medical service expenditures represented 96.6 per cent of the total expenditures for fiscal year 1971.

The amounts expended for each covered service are shown in Table 2. These expenditures represented over three million claims processed by the fiscal agent for the program.

Over 65 per cent of the funds expended for health services was spent for services provided the 75,000 needy aged persons eligible for the program. This is due to their much greater relative need for health services, such as drugs and nursing home care. As expected, the disabled used a large percentage of service in comparison to the number of persons in this category. The distribution of money and eligibles by the program category is shown in Figure 2.

The $36,996,162 spent by the Mississippi Medical Commission in fiscal year 1971 for medical services provided basic health care for Medicaid recipients. Many of the state's most needy citizens received services during the period covered by this report, and, undoubtedly, the Medicaid Program has improved the accessibility of eligible persons to the health care services available in the state.

TABLE 2

EXPENDITURES FOR MEDICAL SERVICE AND AVERAGE SPENT PER ELIGIBLE PERSON BY TYPE OF SERVICE FOR FISCAL YEAR 1971

Type of Service	*Expenditures*	*Average-Spent Per Eligible*
Total	$36,996,162	$177.60
Inpatient Hospital	7,497,566	35.99
Outpatient Hospital	450,956	2.16
Laboratory and X-ray	26,609	0.13
Skilled Nursing Home	8,574,640	41.16
Screening and Diagnostic	121,122	1.15[1]
Physicians	6,339,462	30.43
Home Health	48,844	.23
Emergency Ambulance	16,583	.08
Drugs	8,971,874	43.07
Dental	335,535	1.61
Eyeglasses	14,966	.07
T.B. and Mental Institutions	144,032	1.86[2]
Buy-In, Part B, Medicare	4,453,973	57.66[2]

[1] Only AFDC children are eligible.
[2] Only OAA persons are eligible.

During fiscal year 1971 there were 15,320 hospital discharges with 113,237 days of inpatient hospital care provided by Medicaid. The average length of stay was 7.4 days. Table 3 shows the average length of stay and related information by program category.

Additionally, over 38,000 outpatient hospital visits were provided to Medicaid eligibles in fiscal year 1971.

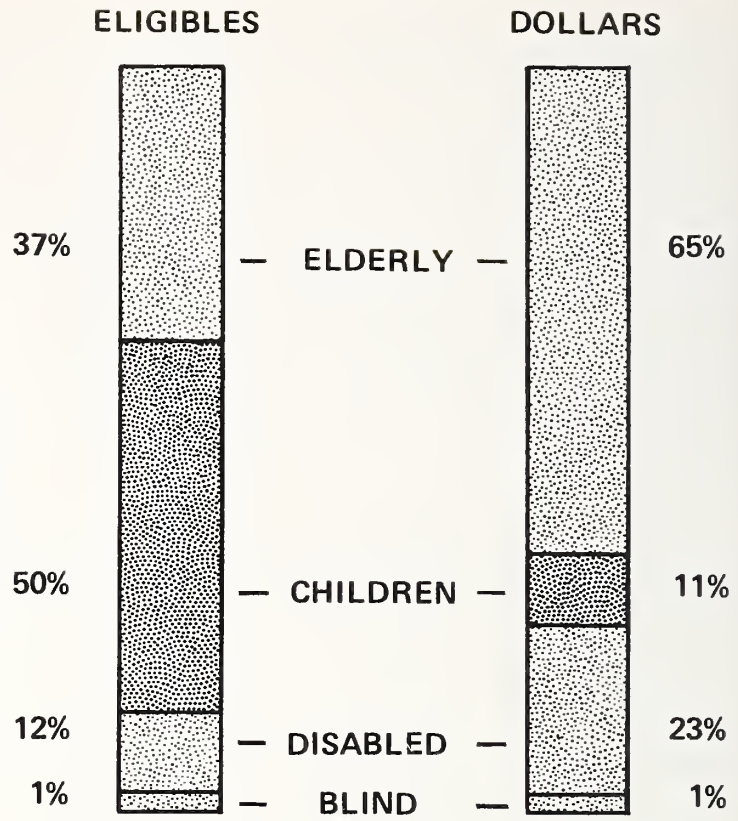


Figure 2. Percentage distribution for persons eligible for medical services and dollars spent by program category for fiscal year 1971.

A total of 955,946 days of skilled nursing home care was provided by Medicaid in fiscal year 1971. The majority of nursing home patients are over 65. Dependent children, blind and disabled used only eight per cent of days of nursing home care covered by Medicaid.

TABLE 3

TOTAL NUMBER OF INPATIENT HOSPITAL DISCHARGES, TOTAL DAYS OF CARE AND AVERAGE LENGTH OF STAY BY PROGRAM CATEGORY FOR FISCAL YEAR 1971

Program Category	*Number of Discharges*	*Days of Care*	*Average Length of Stay*
Total	15,320	113,237	7.4
OAA (Medicaid only)	723	9,777	13.5
AB	501	4,293	8.6
APTD	8,475	72,099	8.5
AFDC	5,621	27,068	4.8

The Mississippi Medicaid Commission paid for 537,364 visits to physicians in fiscal year 1971. The average number of visits per eligible person was 4.1, with persons in the Aid to Permanently and Totally Disabled categories making the greatest number of visits as illustrated in Table 4.

TABLE 4

NUMBER OF PHYSICIANS' VISITS, AVERAGE NUMBER OF ELIGIBLE PERSONS[1] AND AVERAGE NUMBER OF PHYSICIANS' VISITS PER ELIGIBLE PERSON BY PROGRAM CATEGORY FOR FISCAL YEAR 1971

Program Category	*Number of Visits*	*Eligibles*	*Average Visit Per Eligible*
Total	537,364	131,051	4.1
OAA (Medicaid only)	Not Applicable[2]	Not Applicable[2]	Not Applicable[2]
AB	15,674	2,159	7.3
APTD	292,029	23,847	12.2
AFDC	229,661	105,045	2.2

[1] Average Number of Eligibles represents count as of June 30, 1970, plus count as of July 1, 1971, divided by 2.

[2] For OAA eligibles who have not cleared for the Buy-In, Medicaid pays for physicians' services; number of persons in this category has decreased to less than 10,000.

A total of 2,161,340 prescriptions was paid for by the Mississippi Medicaid Program in fiscal year 1971, with an average of 10.4 prescriptions eligible person, as illustrated in Table 5.

TABLE 5

NUMBER OF PRESCRIPTIONS, AVERAGE NUMBER OF ELIGIBLE PERSONS AND AVERAGE NUMBER OF PRESCRIPTIONS PER ELIGIBLE BY PROGRAM CATEGORY FOR FISCAL YEAR 1971

Program Category	*Number of Prescriptions*	*Eligibles*	*Average Rx Per Eligible*
Total	2,161,340	208,302	10.4
OAA	1,438,031	77,251	18.6
AB	29,081	2,159	13.5
APTD	519,325	23,847	21.8
AFDC	174,903	105,045	1.7

SUMMARY

In summary, the Mississippi Medical Program is a relatively limited program with restrictive fiscal controls and fee limitations. To date, the program is operating within its overall budget and is satisfactorily meeting the objective of removing the financial barrier between a segment of the poor population of Mississippi and availability of a reasonable level of quality health care as provided through the existing health care delivery system of the state. ★★★

2906 N. State Street (39216)

OBLIGING DENTIST

Lady to dentist: "I really dread having my tooth pulled. I think I'd almost rather have a baby than have a tooth pulled."

Dentist: "Well, make up your mind, Madam—so I'll know what position to adjust the chair."

Allied Health Personnel in the Internist's Office

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In 1969 the American Society of Internal Medicine surveyed 3500 internists in 1800 offices about current employment and use of allied health professionals in their practice. The survey showed the average number of employees is 2.2 per physician. The number of physicians in the office does not affect the number of allied health professionals who serve each physician, but the smaller the office, the less likely are the personnel to have formal training in health care.

The author points out that in general, clerical and laboratory tasks are usually carried out by the doctors' allied health workers, but physicians rarely delegate patient contact and physical examination tasks to helpers. There is a considerable gap between what the internist believes he could and should entrust to allied health personnel and what he actually does. A substantial number of internists believe that either an R.N. or a physician's assistant can, under supervision, perform aspects of patient care traditionally restricted to the physician.

THERE ARE MANY aspects of the practice of internal medicine which do not require the skill and personal attention of the internist, and the efficient practitioner uses his assistants wisely in order to devote his time to those services which only he can provide. There is near unanimous agreement that the physician need not post and mail the bills nor sweep up the examining room, but there is considerable diversity of opinion about which aspects of patient care, traditionally an integral part of the internists' practice, can be properly delegated to an assistant (man, maid, or machine). There is further disagreement about the type of assistant needed, and how he or she should be trained.

In late 1969 the American Society of Internal Medicine conducted a survey of its membership to find the number and type of assistants now employed, the degree of delegation of various tasks to allied health workers, and the attitudes of internists about which elements of their practice could and should be delegated to assistants. A questionnaire was mailed to a 50 per cent sample of members primarily involved in patient care; each state was represented proportionately to its membership. The response rate was 74 per cent, and the data cover 3425 internists in 1800 offices, employing more than 8500 full-time and part-time workers.

The most frequently encountered health worker is the secretary-receptionist followed closely by the medical assistant. There are roughly equal numbers of registered nurses, lab technicians and medical secretaries. Since the questionnaire specified that the physician's assistant be a graduate of a program such as at Duke University and since such programs are in their infancy, it is not surprising that few internists indicate that they employ such workers. We suspect that the 98 physician's assistants reported is an overestimate and that some respondents misinterpreted the category.

There are regional differences in both number anl type of allied health professionals employed in internists' offices. There is an inverse correlation between number of allied health workers and physician density. In the populous Northeast where physician:population ratio is highest, fewer assistants are employed. Further, a larger percent-

Presented before the Section on Medicine, 103rd Annual Session, Mississippi State Medical Association, Biloxi, May 5, 1971.

From the Department of Internal Medicine, Ochsner Clinic.

age of the workers are in the categories without formal training in patient care (secretary-receptionist, medical secretary, medical assistant).

Size of the office makes little difference in average number of assistants per internist. The U. S. average is 2.22. There is an apparent reduction in number of employees in offices with 10-14 internists, but the data are skewed and the median number of employees in offices of this size is similar to the national average. In a single large multispecialty clinic (33 internists), the number of employees directly serving each internist (2.17) is comparable to that in smaller offices, but when the internists' share of the clinic's administrative, clerical, and maintenance personnel are added, the figure soars to 4.26 employees per internist.

Although the number of employees serving each internist is about the same in both large and small offices, there are significant qualitative differences in allied health personnel. Only 28 per cent of one-man offices employ a registered nurse. The percentage rises to 44 for two-internist offices and to 57 for practices with three. More than 90 per cent of the larger offices with 10-19 internists have registered nurses. Figures for laboratory technicians are similar to those for registered nurses. The most commonly encountered health workers in the solo practitioner's office are the secretary-receptionist (48.7 per cent of offices), medical assistant (44.5 per cent), and the medical secretary (37 per cent).

TRAINING STATUS

In one large clinic only 15 per cent of the internists' allied health workers have formal training in an allied health field, but this relatively low figure is because the sizeable numbers of laboratory technicians and x-ray technologists are considered assistants to the clinic's pathologists and radiologists.

Hiring practices in pediatric offices are similar to those for internists in that Northeastern physicians in both specialties have proportionately fewer of the various forms of allied health workers than in the other regions.[1] Pediatricians employ relatively more registered and licensed practical nurses than do internists. Fifty-seven per cent of pediatric offices have a registered nurse, compared to 39 per cent of internists' offices. Figures for licensed practical nurse employment are 25 per cent and 16 per cent.

The questionnaire listed 42 tasks performed in an internist's office and asked the respondent to indicate who usually performs each duty—only offices in which the task is performed are included in compilation. There is some measure of delegation of each of the 42 tasks, although the range is quite wide.

In general, clerical and business tasks are delegated to an assistant. In 98 per cent of offices someone other than the physician does the billing, and in 85.6 per cent insurance forms are filled out by an allied health worker.

Laboratory tasks also are frequently delegated; less than 10 per cent of physicians perform urinalyses and blood counts. A bigger percentage, and over half the internists in the Northeast, spend time collecting venous blood samples. In 53 per cent of offices (81 per cent in the Northeast) the internist performs skin tests. In over a third of offices in the U. S. and in two-thirds of offices in the Northeast, the internist rather than an allied health worker gives immunizations and intramuscular injections. Intravenous injections are rarely delegated (12 per cent of offices).

MECHANICAL ASPECTS

The more mechanical aspects of the physical examination, such as determining height and weight, taking temperature, screening tests for vision and hearing, are usually delegated to allied health personnel. Blood pressure determination is less often delegated, and the physician almost never entrusts pelvic and proctoscopic examination to anyone other than himself.

Patient contact and history taking tasks are usually not delegated. The single exception is giving telephone advice, which probably is a reflection of the ever present pressure of the telephone. In only 2.5 per cent of offices does an assistant visit patients in nursing homes, and in 15 per cent an assistant visits patients' homes to determine the necessity of the physician calling.

The tasks, when delegated, are carried out by most types of allied health workers, undoubtedly a reflection of the necessity of using the personnel available to the internist. In offices with a laboratory technician the technician is the one who carries out the laboratory tasks, but in offices with no technician, all the other types of health workers, including the medical secretary and secretary-receptionist, perform laboratory tasks.

When a registered nurse or licensed practical nurse is in the office, she is usually the one who performs treatment tasks, but other health workers in varying degrees give immunizations and intramuscular injections. In those few offices where home visits, nursing home visits, and portions of the physical examination are delegated, it is usually to a registered nurse or physician's assistant.

One finding of note is the frequency with which RN, LPN, and physician's assistants are involved in clerical aspects of the practice. In a fairly high

percentage of offices with RNs, the RN sends out bills, fills out insurance forms, and schedules appointments.

There are significant regional differences in the degree of delegation of aspects of the internist's practice. A regional index of delegation was calculated by dividing the percentage of offices in a region delegating a task by the percentage of offices in the U. S. delegating the task. An unweighted average of the 42 tasks is the regional index of delegation. Index of delegation for the U. S. is 100; a value greater than 100 indicates that elements of practice are delegated more often than usual; under 100, less often. There is an inverse correlation between physician:population ratio and the index of delegation.

Region	*Non-federal Physicians in Patient Care Per 100,000 Population*	*Index of Delegation*
Northeast	162	76.5
West	140	96.3
North Central	112	112.9
South	100	114.6
U. S.	125	100.0

The attitudes of internists toward delegation of elements of practice were determined by asking physicians to indicate which of a representative selection of the tasks could and should be carried out by allied health personnel, provided that an appropriately trained person was acting under direct supervision of the internist, that liability was covered, and that there were no legal barriers to performance of the tasks.

Responses indicated that internists are far more willing to delegate aspects of their practice, even those traditionally restricted to the physician, than they now do.

	Could and Should Delegate PER CENT	*Now Delegate* PER CENT
Visiting nursing homes for routine medical rechecks	42.8	2.5
Make home visits to determine necessity of M.D. visit	64.9	15.2
Pelvic exam and Pap smear	6.3	0.8
Pap smear only	33.7	3.1
Proctoscopic exam	9.1	1.1
Take and record routine elements of history	60.3	12.7
Take and record system review	37.4	5.1
Take and record present illness	28.1	4.4

Regional differences in attitude toward delegation are slight, while regional differences in delegation are great.

Views of internists about types of allied health workers who should carry out various functions are generally along the lines of the traditional roles of the workers. Physicians willing to have an assistant assume elements of patient care which the physician now generally does are about equally willing to assign the job to a registered nurse or a physician's assistant. The RN has a slight edge in duties involving therapy (injections, prescription refills, and diet therapy), while the physician's assistant is somewhat more preferred in aspects of the history and physical examination (recording present illness, pelvic and proctoscopic examination, nursing home visits).

CONCLUSIONS

Regional differences in employment of allied health professionals and delegation of tasks may relate to physician density, regional customs, availability of personnel, differences in type of practice or size of office. Attitudes of physicians toward delegation of duties are not greatly different in different areas. The number of allied health personnel is greatest in the area where fewest are employed.

A larger percentage of American Society of Internal Medicine members in the Northeast are solo practitioners (66 per cent vs. 42-43 per cent in other areas). However, the American Academy of Pediatrics survey showed that in offices of comparable size more pediatricians in the Northeast spend time on laboratory, technical and clerical tasks than do pediatricians elsewhere.[1] These observations suggest that availability of physicians, pressure of practice, and demand for services are the most important factors in the extent to which allied health personnel are hired and used.

The internist usually has clerical and laboratory tasks performed by an employee and delegates many of the more mechanical aspects of patient care as well as certain treatment tasks. The person to whom he delegates these items usually depends upon the type of employee present; the smaller the office the less likely there is to be a professionally trained individual (RN, laboratory technician). At the present time the preponderance of employees in internists' offices have not had an educational background in a field of health care. More than half are in the categories of medical assistant, medical secretary, and secretary-receptionist, while a third are in the categories of registered nurse, physician's assistant, licensed practical nurse and laboratory technologist.

The most commonly encountered workers in one and two internist offices are the medical assistant and the secretary-receptionist. The medi-

cal assistant has in the past received primarily on-the-job training. There are now two-year programs in some community colleges for medical assistants, under the auspices of the American Association of Medical Assistants, an organization which is also active in programs of continuing education for its members.

It is likely that the medical assistant will continue to be a mainstay of the physician's office, as many elements of the internist's practice are now efficiently carried out by the worker. Extension of the duties of the medical assistant into aspects of patient care will probably depend more on the aptitude and personality of the assistant, the demands of the practice, and the views of the physician than on the specific educational background of the worker.

Few internists now delegate such elements of patient care as recording the history and making home visits, but many feel that appropriately supervised allied health personnel can carry out these duties. Lack of available personnel and well established practice habits may not be the only factors which create a gulf between what a physician delegates and what he believes he should delegate. The response to this question carried the assumption that there were no legal or liability problems in delegation of a given task, and it is not clear that these are not barriers at this time.

PHYSICIAN'S ASSISTANT

Although few internists currently use a physician's assistant in their practices, responses to the survey indicate familiarity with this type of health worker and a fairly high acceptance of the concept. The physician's assistant ranks on a par with the registered nurse as the health worker with whom the physician will share elements of patient care. In a survey of practicing physicians in Wisconsin, nearly half the internists, general practitioners, and pediatricians indicated that they would use a "doctor's assistant" in their practices.[2]

Internists believe that registered nurses should be more involved in clinical aspects of patient care. A shortage of nurses cannot account for the relatively small quantity of delegation of clinical tasks, as in the 40 per cent of offices which employ nurses, the duties of the RN include many tasks which can be performed by personnel with lesser training and skills. In a time and motion study of six pediatric practices in Seattle, it was observed that there was little role and task distinction between the RN and the medical assistant with six months of training.[3] Schools of nursing are largely hospital based; the majority of RNs are employed by hospitals; there may be considerable carry-over into the physician's office of the institutional concepts of the roles of the nurse and physician in patient care.

Physicians were not limited in their choices of allied health professionals to whom they would delegate aspects of patient care, and there is no clear preference between the RN and the physician's assistant on most items. Even if there were a definite preference, current choice of personnel would be limited by the paucity of physician's assistants available. In terms of future national health manpower needs, it may be difficult to obtain true extension of the physician's services by assigning more aspects of patient care to a health worker already in short supply, as the registered nurse.

The survey indicates that the physician expects the physician's assistant to have the same degree of skill, and presumably education, as the nurse. It can be argued that a re-evaluation of the role of the nurse and expansion of existing programs of nursing education might meet the challenge of expanding ambulatory medical services at less cost and more easily than initiating extensive programs for educating physician's assistants and determining the professional and legal status for a new group. The advocates of the physician's assistant approach foresee that graduates will be specifically trained as physician support personnel skilled in clinical fields, that it will be easier to create a new category of health worker than to reassign clinical roles to a current type of worker, and that the educational programs will attract to the health professions individuals unavailable to and unlikely to enter schools of medicine or nursing.[4] ★★★

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Radiologic Seminar CXII: Radiation Therapy for Peptic Ulcer Disease

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Jackson, Mississippi

WHILE RADIOTHERAPY plays its most useful role in helping to manage malignant disease, there are several benign processes that can be benefitted by irradiation. One of these "benign" diseases that can frequently be helped, but that is not readily acknowledged by most physicians, is chronic duodenal peptic ulcer disease. The patient with long-standing ulcer disease gives a typical history of exacerbations and remissions during which time his attending physician has tried all of the medications available plus perhaps such radical procedures as gastric freezing and various types of surgery. Most of these offer only temporary relief before the patient is again in trouble; the ultimate trouble being massive G.I. hemorrhage.

It has been known since 1921 that[1] irradiation to the stomach reduced gastric hyperacidity. It has been used from time to time with varying degrees of success. In 1959[2] and the early 1960's interest was again revised, and specific treatment methods and policies defined.[3] It was found that the acid producing parietal cells of the gastric fundus and the body were more radiosensitive than the mucous producing cells. It has also been demonstrated that there is a close association between the amount of ulcer-produced pain and free acid. There is also x-ray evidence of decrease in spasm of the stomach and duodenum and rapid decrease in size of ulcer craters following radiotherapy to the upper stomach.

We began treating patients with chronic peptic ulcer disease in the fall of 1964, and since that time have treated a total of 25 patients. The entire course of therapy is given in 10 treatments over a two week period of time. A total dose of 2000 rads is given the the upper half of the stomach through opposing anterior and posterior ports. The patients have all tolerated the treatment well without evidence of nausea or vomiting. Response to therapy is almost immediate, many patients expressing relief of their ulcer symptoms before the course of radiotherapy is completed. In most patients who had their gastric acidity recorded before and after treatment, however, it was noted that several weeks were required before there was a significant decrease in acidity. Obviously there must be some other mechanism at work besides a decrease in acidity to afford the prompt relief of symptoms. This is thought to be a decrease in spasm.

Of the 25 patients treated, only three showed failure to obtain relief of ulcer symptoms. One of these was later explored and found to have a pancreatic tumor with Zollinger-Ellison syndrome. Typically the patients receive prolonged relief of symptoms, some for years. By decreasing the gastric acidity, the chronic ulcer begins to heal naturally and the ulcer medications then become more effective in maintaining a symptom free patient.

J. R. represents a typical patient. He was a 29-year-old white male seen in June 1969, with a long history of peptic ulcer disease and an active duodenal ulcer which was not responding to medications. (See Figure 1.) His free acid pre-irradiation was 38° (102° post histalog) and 40

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Medical Center, Jackson, Miss.



Figure 1. G.I. series on J. R. showing deformity of duodenal bulb and active ulcer crater.

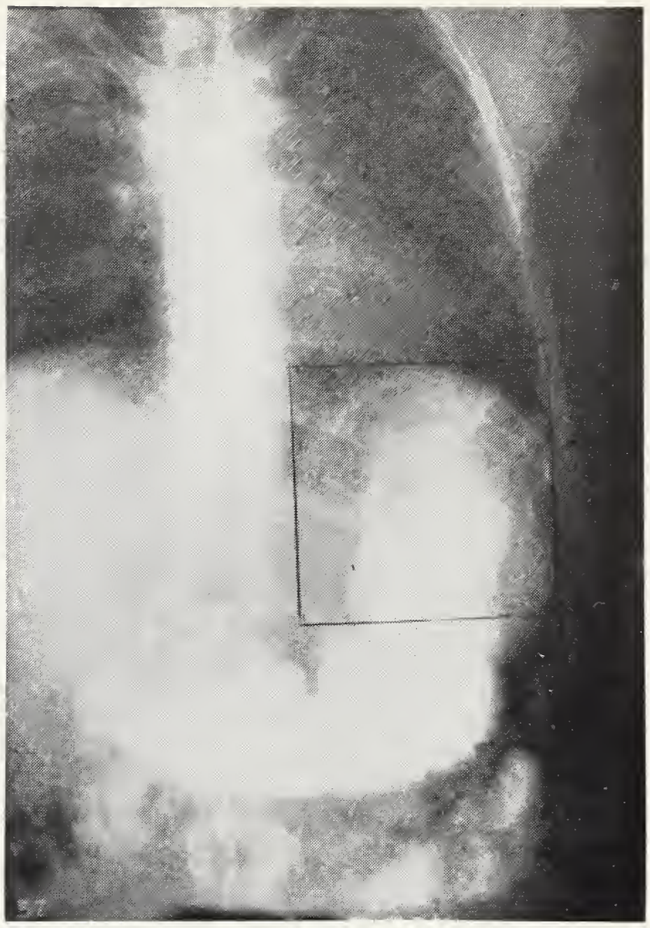


Figure 2. Shows an outline of the portion of the stomach subjected to irradiation. Note that the duodenum and the actual ulcer are not irradiated.

days after irradiation on July 30, 1969 was 5° (22° post histalog). He became symptom free within two weeks of completion of therapy and has remained so to date.

SUMMARY

We feel that irradiation therapy to the stomach has a definite beneficial role to play in the management of chronic peptic ulcer disease. This is most useful in those patients that have an elevated gastric acidity and in those patients that may have only surgery as an alternative. It may also be considered in those patients who are not surgical candidates. ★★★

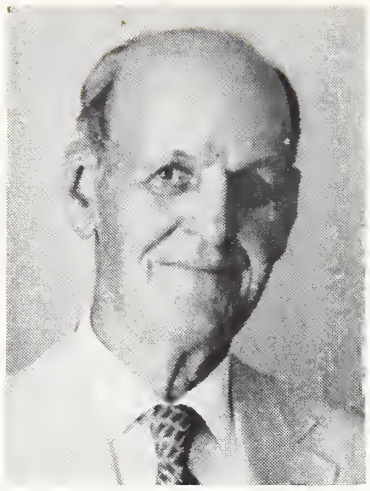
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THEY'LL DO IT EVERY TIME

One of life's mysteries is why children who are light eaters suddenly become ravenous in a restaurant that features hamburgers for $2.85 and cake at a dollar a plate.



The President Speaking

'Full Free Choice—Absolutely'

ARTHUR E. BROWN, M.D.
Columbus, Mississippi

TWO LETTERS CAME to my desk in one day recently. One was an invitation to a symposium in Washington, D. C. on "A National Health Plan: How Much and How Soon?" The other invitation was from Cleveland, Ohio, where a symposium is to be held on the subject of community health and the theme is "After National Health Insurance, What Then?" You will note the question "If" or "When" is not used. National health insurance is being accepted as a reality.

There can be little doubt that in recent years more Americans have been receiving more and usually better medical care than ever before in the nation's history. American medicine is highly pluralistic. Millions of people have government medicine such as those in the Armed Services and in the V.A. hospitals. Several million others have prepaid group organizations and other millions look to out-patient clinics and emergency rooms of hospitals. Medicare, Medicaid and private medical insurance coverage have revolutionized the economics of medical care in recent years.

The existing pluralistic system provides a choice for both physician and patient. The nation's real problems of medical care, such as ghettoes and rural communities, can best be met by means that focus attention on the troubled areas rather than a violent change of the entire complex medical system.

Those who want to use a prepaid group should be allowed to do so. The reformers who want to nationalize medicine are forgetting that nationalization of the postal service and the public school system has led to loss of efficiency and increased cost. If such a medical care system is instituted, it will surely lead to increased cost while providing less satisfaction and poorer treatment for millions of American citizens. At that time there will really be a "health care crisis" in our country. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XII, NUMBER 12

DECEMBER 1971

EDITORIALS

Public Health's Future: Submerged in a Superagency?

I

THE SEVENTH CROSSING of the political River Styx for preventive medicine may be an issue in the 1972 Regular Session of the Mississippi Legislature. Put another way with candor, it adds up to what will be the format, authority, and content of our public health program. But the matter is not unique within the geographic confines of Mississippi, because the issue is one for debate in Washington as the future of the U. S. Public Health Service is in question.

In neighboring Alabama, the legislature is wielding the scalpel as it dissects its Board of Health. Nor is this a regional phenomenon, because there is not a single state board of health in any United States jurisdiction now made up entirely of physicians. Despite the clarity of preventive medicine's role in the health of the nation, the administration of public health has become a mish-mash of interdisciplinary patronage, a catch-all for health related minorities, and a likely candidate for radical statutory surgery.

No longer is the specialty of Gorgas, Reed, Goldberger, and Underwood quite as special as it was when their work alone was the chief factor in lengthening the human life span. With primitive vaccines, insanely imaginative engineering where physicians drained swamps, and crazy theories about nutritional deficiencies, they were saving millions of lives while curative medicine struggled to save dozens. Admittedly, the role of preventive medicine has changed with the forward thrust of medical science, but most physicians agree that there is still a vital and pertinent place for public health. It is to this concern that a statement of the problems surrounding preventive medicine should be seriously addressed, because some politicians seem obsessed with separating public health from the American medical community.

II

The Mississippi State Medical Association successfully sponsored legislation creating the Mississippi State Board of Health. Howard's *History of the Mississippi State Medical Association,* published in 1910, records this action at the 10th Annual Session, conducted at Grenada in 1877 from the report of the Executive Committee (now Board of Trustees):

"After consultation, it was decided to apply to the Legislature for the passage of an act to establish a State Board of Health. Accordingly, a bill was presented at the last session of the Legislature, which, after being completely emasculated and radically altered, was passed, a copy of which, as passed, is herewith presented.

"The present law should be regarded merely as a permissive act," the Executive Committee added but with a note of optimism said that "your committee believes it may be made available in

ultimately accomplishing the objects sought."

The same report related that the state medical association was urging the Legislature to finance "the collection of vital statistics" and to keep hands off any bill "regulating the practice of medicine."

Despite the governing body's criticism of the new enactment, it worked. The Governor appointed nine physicians, respectively representing the nine Congressional districts, as members of the State Board of Health. But the Legislature kept its own counsel with apparent reservations about the new Board, because it refused to make any initial appropriation for it. At the 11th Annual Session in Jackson the next year, 1878, the state medical association appropriated $25 for the Board of Health so that its first annual report might be published.

The Board's uninterrupted record of service to the state is documented with distinction under the leadership of outstanding state health officers. The late Dr. Felix J. Underwood served as president of the American Public Health Association and became a Lasker Award laureate. But today is a different story.

III

The role of public health in the United States is being submerged into state superagencies, and professionalism is being stripped of its individuality. Fifteen state health officers are now at least two levels below the governor of their respective states. Seven states have no boards of health at all, and in all but 20 states, the board of health has no role in appointing the state health officer.

Physicians are in a minority on 21 state boards of health, and in Idaho, New Mexico, and South Dakota, only one doctor of medicine is on each board of health. Of 43 boards recently studied by APHA, membership representation, in addition to physicians and dentists, included osteopaths, engineers, attorneys, veterinarians, optometrists, pharmacists, state and local government officials, nurses, hospital administrators, nursing home operators, chiropractors, and of course, consumers.

Only two state boards of health in the nation have more than seven physicians as members: Georgia and Mississippi. The former has 10 MDs among 18, while we have nine out of 11. Most boards are made up of 12 members, but the median is fewer. Most board members serve terms of four years which is also the median term.

During the 1971 Regular Session of the Mississippi Legislature, there were two major attacks on the present and historic statutory organization and format of the State Board of Health. One series of bills originated with the Division of Comprehensive Health Planning and the other, with the Governor's Commission on Reorganization of State Government.

The CHP series, consisting of 17 bills, would have abolished the Board, assigning its functions to a proposed superagency, the Commission for Health Programs. The seven commissioners, according to the proposal, would be nonprofessionals in the health field. Public health functions would have been divided among three subagencies, those for health resources programs, medical care programs, and community health programs. County health departments would have been abolished, being replaced by 10 regional health units serving multicounty areas.

The Governor's Blue Ribbon Commission proposed less radical surgery. It would have consolidated the Board of Health and the Department, really the staff, and provided for significant changes in functions.

The plan called for divesting the Board of Health from its Division of School Health, transferring this activity to the Department of Education. Three other functional transfers were involved: The State Sanatarium, nursing home licensure, and licensure of physicians, osteopaths, and podiatrists, the latter being transferred to the



"Boy, is he ever a tough-skinned old bird!"

Department of Commerce where, under the Governor's commission, all professional licensure would have been lumped.

IV

Much of this hue and cry comes from those who feel a need for reorganization of state government, and to be sure, some reorganization appears to be long overdue. But little constructive realignment and improvement of governmental efficiency will likely emerge from hasty, radical change. Historically, public health has been apart from politics, and wisely so, because there can be no majority and minority on matters of the best health for every citizen.

In the two major reorganization efforts seen in the 1971 Regular Session of the Legislature, neither was presented to the state medical association prior to introduction nor was there coordination with other health-related organizations. Such consultation is obviously appropriate, and many members of the House and Senate were aware of this oversight.

Preventive medicine is not apart from the clinical community, and more than ever, all of American medicine needs to be united. Perhaps the 1972 Regular Session of the Mississippi Legislature will come to Jackson in January with a better understanding of this toward the end of best serving the health of all Mississippians.—R.B.K.

Problems in Disposition of a Medical Practice

The disposition of a medical practice by sale, replacement with a new physician, death, or removal of the previously established practitioner raises knotty legal questions. Out-and-out sales of medical practices from one physician to another are relatively rare, certainly in contrast to a generation or more ago. These questions arise today more frequently following death of an established practitioner or upon dissolution of a partnership, group, or corporation.

With the advent of professional corporations, legal arrangements among the practitioner-incorporators usually provide for what attorneys call a "buy and sell" arrangement. It generally means that surviving incorporators would purchase the share of the deceased member, and in many instances, this purchase is funded by life insurance secured specifically for such purpose. Usually, the purchase proceeds are paid into the estate of the deceased physician after satisfaction of his share of the partnership's or corporation's debts.

A second advantage of "buy and sell" agreements is that they relieve the surviving practitioner partners or corporate members and the estate of the deceased physician from the difficulty and unpleasant task of negotiating a purchase price.

Three other important aspects appear in disposing of a medical practice. They are physical assets, office lease, and goodwill. A well-equipped office usually represents a substantial investment, and some specialty practices, such as radiology, involve very great investments. Because of tax laws governing liability for taxes with such sales, it is always in order to consult an attorney and an accountant (C.P.A.) when reporting income from the proceeds of such sales.

A lease on professional premises amounts to a continuing obligation to pay rent for a stated period of time, so the sale or disposition of a practice with a lease usually lists the latter as goodwill. Of course, provision to sublease does not, as a rule, release the original lessor from his obligations, and if the subtenant defaults payment, the original lessor or his estate may be in the position of guarantor. But the lease may be a valuable asset in a highly desirable practice location, thus adding to the value of the practice.

Since goodwill is intangible, it is difficult to place a dollar value on it. Moreover, goodwill is a capital asset which cannot be depreciated, so the seller must pay capital gains tax on all proceeds realized from this portion of the sale. Sometimes this intangible part of the practice is covered in a "covenant not to compete," meaning that the seller may not engage in medical practice within a given area for a stated length of time.

In the disposition of a medical practice, more questions arise over patient records than any other aspect. This is also the most delicate part of the disposition from a legal point of view.

The courts have consistently held that patient records are the property of the physician, not the patient. The patient purchases medical care and not a record of it. The Office of the AMA General Counsel states that patient records "are maintained by the physician primarily for the purpose of assisting him in the diagnosis and treatment of the patient and everything included in those records is protected from disclosure by the physician as confidential information."

Patient records may be transferred to another physician, but only with the consent of the patient. Such authorization by the patient should be in writing. Thus, in purchase or disposition of a practice of a retiring or deceased physician, the purchasing physician may not acquire the medical records of the patients without expressed written

consent. The *Principles of Medical Ethics* forbid solicitation of this consent.

It is, however, entirely proper for the retiring physician or the estate of a deceased physician to inform patients of the retirement or death, advising that the patient may make a written request for a transfer of records to another physician.

Patients who do not request such a transfer of records make for another problem. Destruction of the records may be a disservice to the estate, in cases of death, since the records may be the only defense against a subsequently filed professional liability suit. Retention of the records until expiration of the statute of limitations, six years in Mississippi, is legally desirable. But it is also a burden, for the statute does not begin to run until the patient is 21 years of age. This means keeping records on a newborn for 27 years.

There are other considerations in the disposition of a practice for which advice and assistance are available from medical associations, attorneys, accountants, and various government agencies. The latter would include assistance on disposing of drug stocks, licensure considerations, and the like.

Disposition of a practice will involve inconveniences and even burdens, but many of these aspects are too serious and important to treat casually.—R.B.K.

The Great Combination Ingredient Flap

The great flap over combination ingredient drug products is apparently resolved. A year ago, the Food and Drug Administration announced promulgation of extremely restrictive regulations prohibiting the marketing of drug products with more than one ingredient, unless it was demonstrated to the satisfaction of FDA that each added ingredient would enhance the effectiveness of the product by increasing potency or prolonging its effect.

Additionally, the regulations would have required that the combination would have increased the safety of the product by decreasing or reducing severity of adverse effects or preventing misuse and abuse. Clearly, the regulations were, in the words of Resolution No. 5, adopted at the 103rd Annual Session last May, "an incursion in and usurpation of medical practice by the Food and Drug Administration."

The association's House of Delegates opposed issuance of the regulations "to remove from the physician's therapeutic armamentarium combination drug products, thereby denying him and his patient the convenience and economy of many proven products."

"We believe," the House of Delegates continued, "that this policy can and will result in government usurpation of medical practice, a needless increase in the cost of drugs to the patient, and a waste of research and clinical manpower, facilities, and expense in satisfying these restrictive requirements."

With many other state medical associations and national organizations taking the same position, including a sharp protest by the American Medical Association, probably most influential of all, the FDA receded from its inflexible position, and the entire issue was reviewed. Now regulations have been issued which are far more reasonable, less arbitrary, and more generally acceptable to the practicing profession.

The new regulations have these four main points:

—A fixed combination product may not be marketed unless it offers the patient a therapeutic advantage over any of the components administered separately.

—Two or more drugs may be combined in a single dosage form when each contributes to the claimed effects.



"We have a rather extensive line, sir . . . did you want that for a single or double hernia?"

—A licensed combination product which is changed by the manufacturer to meet requirements set upon review by the National Academy of Sciences-National Research Council will meet these new FDA requirements.

—Requirements are considered to have been met if a combination is judged effective by FDA on NAS-NRC studies.

In effect and essence, these reasonable and commonsense ground rules are about what medicine and the ethical pharmaceutical manufacturing industry have been striving for. A drug is as safe and effective as science can make it. Moreover, the real customers of the pharmaceutical manufacturers are the physicians, not the patients who receive the drugs. Practitioners are critical judges of therapeutic effectiveness who weigh carefully any untoward effects brought about by use of the drug product. The competitive market place where human health is at stake will make the severest judgment of all.

If there is a moral to this story of the flap over combination ingredient drug products, it is this: When and if regulations are to be issued on what may be marketed for use by physicians, the practitioners themselves must be consulted and their joint and respective clinical judgments weighed heavily in the interest of patient care and the efficient delivery of medical services at the most reasonable cost consistent with care quality which may not be compromised.—R.B.K.

The Phenomenon of the Medical Care Dollar

There are medical economists, and then there are (other) medical economists. The point is that one group, up to its academic ears in tortured logic, bewails the costs of medical care, usually indicting providers for the upward spiral. The other group tries to analyze the facts objectively, but somehow their findings seem to be submerged in the clamor, hue, and cry of unacceptably high medical care costs.

Here are some of the economic findings which, more often than not, are subjected to tenuous interpretation not altogether favorable to the American health care team:

—In 20 years from 1950 through 1970, the nation's health care bill rose to $67.2 billion from $12.1 billion, or to 7.0 per cent of the Gross National Product from 4.6 per cent in 1950.

—The private share of the medical care dollar is shrinking while the federal or public share grows, up to 25 per cent federal in 1970 from 13 per cent in 1966.

—The annual rate of cost increase for medical expenditures during 1966-69 is twice as great as the annual rate of increase on all consumer items, 6.4 per cent for medical against 3.8 per cent for all goods and services.

Let's examine these economic generalities as they apply to health care costs, beginning with the percentage of the Gross National Product. To the noneconomist, the GNP often is seen in terms of hard dollars paid and received with a purchase. Not exactly so, for the GNP is the *value*—estimated, at that—of all goods and services generated by the nation in a year. This does not mean that the goods and services necessarily produced the *wealth in dollars* that their value should represent.

For example, a physician may generate $10 in the value of the GNP during an office visit with the rendering of a given service. He may receive, however, only $4 for the service under a stated medical care plan. This constitutes a wide disparity between the service value and the receipt for the sale of the service.

Then there is the fundamental difference between *cost* and *expenditure*. It is obvious that expenditures rise when more of a product or service is purchased, even though cost remains the same. So this ties into the second generality as well as the first. It was the political sector—not the private—which brought about Medicare and Medicaid in 1966, infusing nearly $11 billion annually into health services purchase. And for three years, there was little exercise of restraint upon beneficiaries who, it must be conceded, utilized services frequently and in some instances, beyond actual medical need.

And finally, this business of the rate of increase in care costs: It is often made to sound as if care providers and medical facilities raised prices at will on no provocation other than to grab the loot. Since 1950, 47 per cent of health care cost increases are attributable to general price hikes, and this amounts to $22 billion of the present bill.

Another 17 per cent, $8.3 billion, is the result of population growth. After all, when there are *more* consumers of medical services, the expenditure is bound to increase. The remaining 36 per cent, $17 billion, does result from increased utilization of services, but more often than not, with good and sufficient reason. Previously, many such individuals did not receive adequate health care services at all. Then what of new and sometimes expensive services, open heart surgery, hemodialysis, and the like? In 1950, they were not available at any price.

Finally, most statistics include nonpersonal health services in the nation's health care expenditures. These include research, medical facilities construction, disease detection screening, community projects, and even aspects of preventive medicine in sanitation.

The frosting on the cake is a study made by the Michigan State Medical Society. It reports that during 1966-70, medical practice revenue (in the study sample) increased 33 per cent. But in the same period, nonowner physician (employed MDs) salaries advanced over 5 per cent, and nonphysician (RNs, technologists, therapists) salaries went up 40 per cent. Payroll taxes and fringe benefits for all employed personnel in health services increased by 100 per cent, and drugs, medical supplies, and laboratory services were up 25 per cent.

Occupancy or rent on practice premises zoomed 39 per cent, and insurance premiums advanced by 97 per cent. A new automobile went up by 27 per cent, and all other items implicit in health care delivery were up 35 per cent.

It all added up to an increase in the cost of practice by 40 per cent, while income increased 33 per cent. And this revenue increase is often brought about by greater productivity and longer working hours serving patients, not entirely by raising professional fees.

So when an economist starts reciting figures on the high costs of medical care, make certain that he or she puts the information in true context, for the phenomenon of the medical care dollar is sometimes an economic shell game.—R.B.K.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Dec. 6-10, 1971

NEUROLOGICAL DISEASE AND STROKE INTENSIVE COURSE

University Medical Center, Jackson
Dec. 6-10, 1971, beginning at 8 a.m.

Sponsored by The University of Mississippi School of Medicine, with the support of the Mississippi Regional Medical Program

Coordinators:

Robert D. Currier, M.D., professor of medicine (neurology), The University of Mississippi School of Medicine, and co-director, demonstration stroke unit, Mississippi Regional Medical Program

Armin Haerer, M.D., associate professor of medicine (neurology), The University of Mississippi School of Medicine

The first of a two-part offering, the Dec. stroke intensive course will emphasize the team approach to stroke and neurological disease patient management by including content for nurses and therapists. The course, a pilot project, is presented to stroke teams from a given community. Some sessions will be held with each professional group individually, while others will incorporate the full team.

The eight one-week intensive courses offered through the Mississippi Postgraduate Institute in the Medical Sciences are designed for the family physician. Registration for each class, presented twice during the year, is limited to physicians enrolled in the Institute, which is funded by the Mississippi Regional Medical Program.

FUTURE CALENDAR

November 29-December 3, 1971
OBSTETRICS INTENSIVE COURSE

December 6-10
STROKE AND NEUROLOGICAL DISEASE INTENSIVE COURSE

January 5, 1972
CIRCUIT COURSE, BILOXI

January 10-14
ELECTROCARDIOGRAPHY INTENSIVE COURSE

January 11
CIRCUIT COURSE, MCCOMB

February 2
CIRCUIT COURSE, GULFPORT

February 7-11
GASTROENTEROLOGY INTENSIVE COURSE

February 14-16
CARE OF ACUTE CARDIAC PATIENTS, BILOXI
Mississippi Heart Association

February 22
CIRCUIT COURSE, COLUMBUS

March 1
CIRCUIT COURSE, BAY ST. LOUIS (to be confirmed)

March 2
CIRCUIT COURSE, HATTIESBURG

March 9
CIRCUIT COURSE, HATTIESBURG

March 13-17
OBSTETRICS INTENSIVE COURSE
STROKE AND NEUROLOGICAL DISEASE INTENSIVE COURSE

March 16
CIRCUIT COURSE, HATTIESBURG

March 20-24
CARDIOLOGY INTENSIVE COURSE

April 10-14
PEDIATRICS INTENSIVE COURSE

April 11
CIRCUIT COURSE, MCCOMB

April 17-21
CARDIOLOGY INTENSIVE COURSE

April 24-28
RADIOLOGY INTENSIVE COURSE

April 25
CIRCUIT COURSE, COLUMBUS

May 1-5
NEPHROLOGY INTENSIVE COURSE

May 8-11
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

NEW MEMBERS

HUDGINS, W. ROBERT, Jackson. Born Ft. Worth, Tex., Mar. 10, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned Duke Hospital, Durham, N. C., one year; neurosurgery residency, University of Tennessee, Memphis, July, 1965-July, 1969; elected Sept. 1971 by Central Medical Society.

HUGGINS, GEORGE RICHARDSON, Jackson. Born St. Louis, Mo., Oct. 18, 1937; M.D., University of Missouri School of Medicine, 1963; interned Barnes Hospital, St. Louis, one year; ob-gyn residency, University of Missouri, Columbia, 1964-1967; elected Sept. 1971 by Central Medical Society.

LEE, MARY ALICE, Jackson. Born Waynesboro, Miss., June 12, 1932; M.D., University of Tennessee College of Medicine, Memphis, 1956; interned UMC, Jackson, Miss., one year; psychiatry residency, same, July 1, 1961-June 30, 1964; elected Sept. 1971 by Central Medical Society.

MULLEN, JESSE GAEL, Jackson. Born New Orleans, La., Nov. 11, 1932; M.D., Louisiana State University School of Medicine, New Orleans, 1958; interned Southern Baptist Hospital, New Orleans, one year; anesthesiology residency, Charity Hospital, New Orleans, July 1, 1959-June 30, 1961; elected Sept. 1971 by Central Medical Society.

DEATHS

BETHEA, STANFORD ERNEST, SR., Hattiesburg. M.D., Tulane University School of Medicine, New Orleans, La., 1919; interned Touro Infirmary, New Orleans, for one year; died Oct. 25, 1971, age 78.

CAMPBELL, GEORGE ALEXANDER, West Point. M.D., Tulane University School of Medicine in New Orleans, La., 1924; interned U. S. Marine Hospital, New Orleans, one year; died Oct. 29, 1971, age 68.

FERGUSON, SILOUS CYLE, Meridian. M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1943; interned Baroness-Erlanger Hospital, Chattanooga, Tenn., Jan. 1, 1944-June 30, 1965; died Oct. 14, 1971, age 54.

FLEMING, TUCKER YOUNG, Minter City. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1911; interned St. Joseph's Hospital, Memphis, one year; past president of Leflore Co. Medical Society; presented Golden "T" by University of Tennessee in 1961; member of Fifty Year Club MSMA; died Aug. 24, 1971, age 83.

POWELL, M. M., SR., Coldwater. M.D., University of Louisville School of Medicine, Louisville, Ky., 1911; interned Louisville Hospital, Louisville, one year; member of the Fifty Year Club MSMA; Emeritus member of MSMA and AMA; died June 18, 1971, age 87.

WERLEIN, PRESLEY EWING, Biloxi. M.D., Tulane University School of Medicine, New Orleans, La., 1914; interned O'Conner Hospital, San Jose, Calif., for one year; EENT residency, Charity Hospital and EENT Hospital, New Orleans; member of the Fifty Year Club of MSMA; Emeritus member of MSMA and AMA; died Oct. 22, 1971, age 80.

PERSONALS

ROBERT D. CURRIER of Jackson has been named to serve on the committee on prevention and clinical services of the Developmental Disabilities Advisory Council.

L. STACY DAVIDSON, JR. of Cleveland spoke on glaucoma at the October meeting of the North Delta District Nurses Association held at Coahoma County Hospital.

A. R. DILL of Columbus has become a Diplomate of the American Board of Internal Medicine after successfully completing examination in Philadelphia, Penn.

JAMES B. FALKER announces the opening of his office for the practice of ophthalmology at 214 W. Washington Street, Aven Building in Greenwood.

New officers of the Delta Medical Society are Drs. GEORGE F. ARCHER of Greenville, president; JOHN C. SUARES of Greenville, vice president; and WALTER H. ROSE of Indianola, secretary-treasurer. TOXIE H. HALL of Belzoni is past president.

VERNON B. HARRISON of Oxford has retired as director of the Student Health Service at Ole Miss.

JAMES H. HENDRIX, JR., of Jackson has been elected vice president of the American Society of Plastic and Reconstructive Surgeons.

R. E. JENNINGS of Taylorsville conducted a cardiopulmonary resuscitation training session for the hospital staff at Perry County General Hospital.

BEN B. JOHNSON of Jackson has been named new chairman of the medical advisory board of the Kidney Foundation of Mississippi.

HERBERT G. LANGFORD of Jackson was guest speaker at the October lecture series of Rush Foundation Hospital in Meridian. Dr. Langford discussed "Care of the Hypertensive Patient."

CHESTER MASTERSON of Vicksburg is the new president of the West Mississippi Medical Society. Other officers are CHARLES MARASCALCO, vice president; M. E. HINMAN, secretary; and W. K. PURKS, program chairman.

SHELBY W. MITCHELL of Clinton was elected to head the administrative section of the Mississippi Public Health Association at the annual meeting in Jackson.

JOHN D. MORGAN of McComb, JOHN R. WILLIAMS of Greenville, CLYDE A. WATKINS of Sanatorium, BERNARD BOOTH, JOHN F. BUSEY, JACK RATLIFF, JOE R. NORMAN, WALTER TREADWELL, and MYRA TYLER, all of Jackson, were on the program of the special pulmonary seminar sponsored by the Mississippi Thoracic Society and held at the University Medical Center in Jackson.

KENNETH N. REED has associated with RALPH SNEED, HOWARD B. CHEEK, and JAMES D. GORDON at the Jackson Ear, Nose and Throat Clinic at 916 North State Street.

ROLAND B. ROBERTSON of Jackson is serving as president of the Mississippi Thoracic Society.

ROBERT B. THOMPSON announces the opening of his office for the practice of hematology and cancer chemotherapy at the Medical Towers Building, 440 East Woodrow Wilson in Jackson.

W. W. WALLEY of Waynesboro recently was guest speaker at the Waynesboro Rotary Club. Dr. Walley spoke on the drug problem.

HORACE C. WATKINS, III, has associated with WILLIAM W. MAYERS of Laurel in the practice of urology at 364 South 10th Avenue.

FRANK M. WIYGUL, JR., of Jackson was named chairman of the committee on prevention and clinical services of the Developmental Disabilities Advisory Council.

Dr. Patrick Chosen Neurological Head

Dr. Bernard S. Patrick, neurosurgery associate professor at The University of Mississippi School of Medicine, was chosen president-elect of the Congress of Neurological Surgeons at the annual meeting in Miami Beach in October.

A native Mississippian, Dr. Patrick was secretary of the Congress for three years prior to his present post as president-elect.

The Congress of Neurological Surgeons is an international organization with more than 1,300 members in the United States and 25 foreign countries.

Book Review

Speech Pathology: An Applied Behavioral Science. By William H. Perkins, Ph.D., 449 pages with illustrations. St. Louis: The C. V. Mosby Company, 1971. $11.75.

Speech pathology has a long history. In Europe and those countries that are influenced by its culture, such as Japan, speech pathology traditionally has been a medical specialty, usually within otolaryngology. American speech pathology has gone its own way, developing chiefly from phonetics, psychology, and education. This work presents a radical departure from both schools in that it puts the behavioral science in the foreground, it offers a totally different approach, and it proceeds from very new viewpoints. This emphasis on behavior offers fresh thoughts and sheds new light on many old problems.

Another value is the thorough preparation of the material which presents an up to date outline of the most recent research. Again, the data are reviewed with the new orientation toward the behavioral aspects of communication. While these thoughts are highly stimulating, the reading is not easy for the physician who is used to the foundation of clinical medicine on the measurable facts of its basic sciences.

The work is organized into five parts within two main sections, namely, Speech Science, Disabilities of Speech, Disorders of Speech, Clinical Practice of Speech Pathology, and Speech Pathology as a Profession. The appendix includes a representative list of journals, abstracting services, and other reference lists. Another innovation is the inclusion of questions to the reader, as if to stimulate a discussion session with the author. Numerous illustrations reinforce the text, sometimes even with humor. A list of modern references concludes each chapter.

In this time of large books often written by numerous authors, the single authorship of so large a volume offers the advantage of uniformity without overlapping redundancy. Most chapters are of evenly high quality, even though the one on stuttering appears to have been written with especial dedication. On the other hand, the problem of cluttering is viewed with skepticism. This is surprising because the diametrically different behaviors of the stutterer and clutterer should be a special challenge to the behaviorist. It is gratifying to see the high standard of technical production. Printing errors are refreshingly inconspicuous.

In view of these many fine qualities, a few flaws are hardly worth mentioning. For example, the standard abbreviation for decibel is dB (because Bell is a name); sensori-neural is officially spelled with hyphen (to emphasize the "and/or" implication); and the term "global aphasia" could be defined with better precision (to stress its difference from a "total" aphasia). The book is to be highly recommended to all speech pathologists and to those physicians who deal with the various problems of communicative disorders.

G. E. Arnold, M.D.

ACS Inducts Eight State Surgeons

Eight Mississippians were among approximately 1,475 surgeons inducted as new Fellows (members) of the American College of Surgeons in cap-and-gown ceremonies during the annual five-day Clinical Congress of the world's largest organization of surgeons.

Fellowship, a degree entitling the recipient to the designation "F.A.C.S." following the doctor's name, is awarded to those surgeons who fulfill comprehensive requirements of acceptable medical education and advanced training as specialists in one of the branches of surgery, and who give evidence of good moral character and ethical practice.

The 1971 initiates are Drs. Thomas L. Kilgore, Jr., and Richard C. Miller of Jackson; William H. Henderson of Oxford; Harry E. Burrow, Jr., and Clarence D. Whigham of Pascagoula; John W. Bowlin of Tupelo; Chester W. Masterson and Frank T. McPherson of Vicksburg.

The American College of Surgeons is a voluntary scientific and educational association of surgeons, numbering 32,000 in approximately 100 countries. The College was founded in 1913 to improve care of the surgical patient, and has pioneered in many directions in making surgical care as excellent as it is today.

CHAMPUS Announces New Claims Address

Due to a recent consolidation of the 4th and 5th United States Armies, the addresses to which medical care claims should be sent for active duty servicemen in these areas have been changed, according to Col. E. V. Allen, MSC, USA, Director of Contract Management.

CHAMPUS claims for civilian dependents will be sent, as always, to the Mississippi State Medical Association, 735 Riverside Drive, Jackson, Miss. 39216.

The address for Mississippi is Headquarters Third U. S. Army, Commanding General, Third United States Army, ATTN: Surgeon, Fort McPherson, Ga. 30330.

UMC Establishes School of Allied Health

The University of Mississippi has established a School of Allied Health at the University Medical Center at Jackson, according to Chancellor Porter L. Fortune.

The Board of Trustees, Institutions of Higher Learning, approved creation of the new school at the Oct. 22 meeting on the Oxford campus.

Initially, said Chancellor Fortune, the school will coordinate the ongoing bachelor's degree programs in medical technology, dental hygiene and medical record librarianship. A degree in physical therapy, currently nonexistent in Mississippi, will be added as soon as possible.

"The school will be viewed as a cooperative effort between the Medical Center, the University in Oxford, and other colleges, universities and hospitals which choose to be affiliated," he explained.

As the state's only institution which unites medical, nursing, and allied health undergraduate, graduate and postgraduate education and research with a teaching hospital, the Medical Center will provide students in the allied health fields with topnotch clinical experience.

Prompted by the acute shortage of well-trained allied health personnel and technicians in Mississippi, the new school will coordinate the variety of allied health professions that have been added to medicine and nursing since the Medical Center opened in 1955. In addition to the baccalaureate programs, they include x-ray and clinical nuclear medicine technology, cytotechnology, nurse-midwifery, and nurse anethesia. Hospital-based technician programs have also been offered in cooperation with the public schools and local junior colleges.

Chancellor Fortune has appointed a committee to search for qualified candidates for the dean of the School of Allied Health at the Medical Center. An associate dean in Oxford will coordinate the basic general education offered on the Ole Miss campus in preparation for clinical experience.

Dr. Chenault Visits MSMA Headquarters

Attracting more than a fair share of distinguished medical leaders, the state medical association's EMCRO (Experimental Medical Care Review Organization) was visited by Dr. John M. Chenault of Decatur, Ala., secretary-treasurer of AMA and a member of its Board of Trustees. He is also chairman of the Board of the Medical Association of the State of Alabama.



Dr. John M. Chenault of Decatur, Ala., left, AMA secretary-treasurer and a member of the Board of Trustees, discusses the Mississippi EMCRO program with Hilton C. Bowers, MSMA director, Division of Medical Care Plans.

Dr. Chenault said that the direction of medical organization in the United States is toward physician-oriented peer review and foundations for medical care. He commended the Mississippi State Medical Association for its work in quality care review, organization of the new foundation, and for long service in medical care plan administration, the CHAMPUS program.

The AMA leader is also president of the American Medical Association Education and Research Foundation (AMA-ERF).

Drs. Martin and Brown Announce Format for the 104th Annual Session

New format and new concept are the key phrases characterizing the 104th Annual Session set for Biloxi, May 8-11, 1972. This was the announcement of Dr. Raymond S. Martin, Jr., of Jackson, chairman of the Council on Scientific Assembly, and Dr. Arthur E. Brown of Columbus, president of the association.

The association leaders said that for the 1972 session only, the scientific program is under the guidance of the several specialty societies. Through appropriate section officers, the groups are being consulted on program topics and essayists.

"We are also recognizing the impact of socioeconomics upon medical practice and delivery of health care," Drs. Martin and Brown said.

"The council has scheduled two plenary sessions on socioeconomics for the mornings of May 9 and 10. The first, on Tuesday morning, will be a full presentation on the Mississippi Foundation for Medical Care and peer review as conducted by the association's EMCRO (Experimental Medical Care Review Organization) project.



Dr. Martin

"On Wednesday," the leaders continued, "we will have a dual-subject plenary session on professional liability and professional corporations."

On the meeting agenda are the House of Delegates and reference committees for Monday with the final meeting of the policy-making body scheduled for Thursday afternoon. Three half-day general scientific sessions will feature surgery, obstetrics and gynecology, medicine, preventive medicine, family practice, EENT, and pediatrics.

Drs. Martin and Brown said that as many as 12 specialty societies will meet concurrently with the annual session, generally selecting a day adjunctive to general scientific meetings concerned with the particular specialty. Of interest will be specialty society luncheons and dinner occasions.



Dr. Brown

The Woman's Auxiliary will meet concurrently with the annual session, all of which will be headquartered in the still-new Sheraton-Biloxi. Full facilities of the 350 room convention hotel have been contracted by the association.

Dr. Martin said that medical alumni groups representing Ole Miss, Tulane, Tennessee, and Vanderbilt are scheduling evening social occasions. Ole Miss will meet on Monday, May 8, both in a business session and for an evening dinner and dance party. Tulane, Tennessee, and Vanderbilt medical alumni will meet on Tuesday evening, Dr. Martin said.

Expected to meet during the 104th Annual Session are the Mississippi Academy of Family Physicians, Society of Internal Medicine, Ob-Gyn Society, EENT Association, Association of Pathologists, Psychiatric Association, Radiological Society, American College of Surgeons, and Urological Society.

Special events will include the Fifty Year Club, Flying Physicians, and other group luncheons. A golf tournament, probably in revised format to eliminate conflict with a single meeting, is in the making.

Delegates will meet on Monday to receive reports and resolutions which will be discussed before reference committees that afternoon. The Nominating Committee will conduct open sessions Wednesday, and on Thursday, the House will take final actions on business and policy, electing 1972-73 officers as the final order of business.

Dr. C. R. Jenkins of Laurel will be inaugurated 1972 president at the adjourned meeting of the House of Delegates, and new officers will assume their respective posts at that time.

Dr. Martin said that the Scientific and Technical exhibits will be located on the second level of the Sheraton-Biloxi where most specialty society meetings and all general and plenary sessions will be conducted.

The hotel has constructed two new meeting rooms since the May 1971 annual session, giving the association more and better space for smaller meetings and social occasions.

Room blocks are available at adjacent hotels and new motels, giving the convention 600 air conditioned rooms and suites.

SAMA—MECO Plans 1972 Summer Program

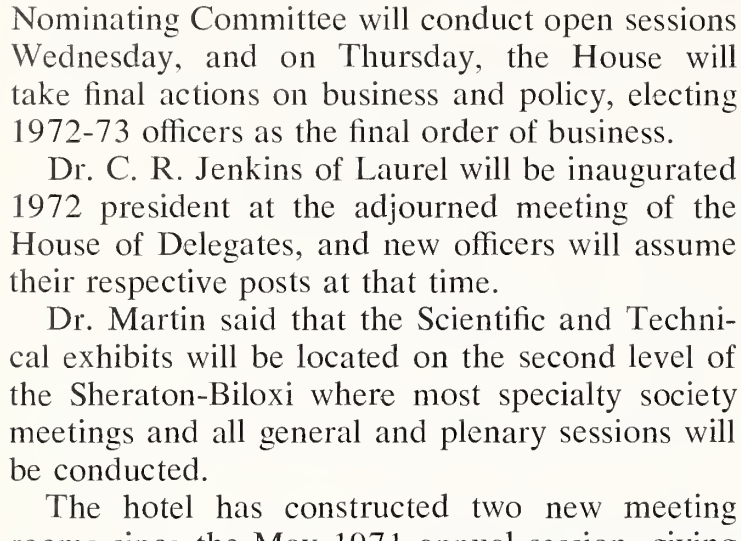
Plans are now underway for implementing MECO, the Medical Education-Community Orientation program for Mississippi, for the summer months of 1972.

MECO will again be sponsored by the Student American Medical Association chapter of the University of Mississippi School of Medicine with the support of the Mississippi Hospital Association and the state medical association.

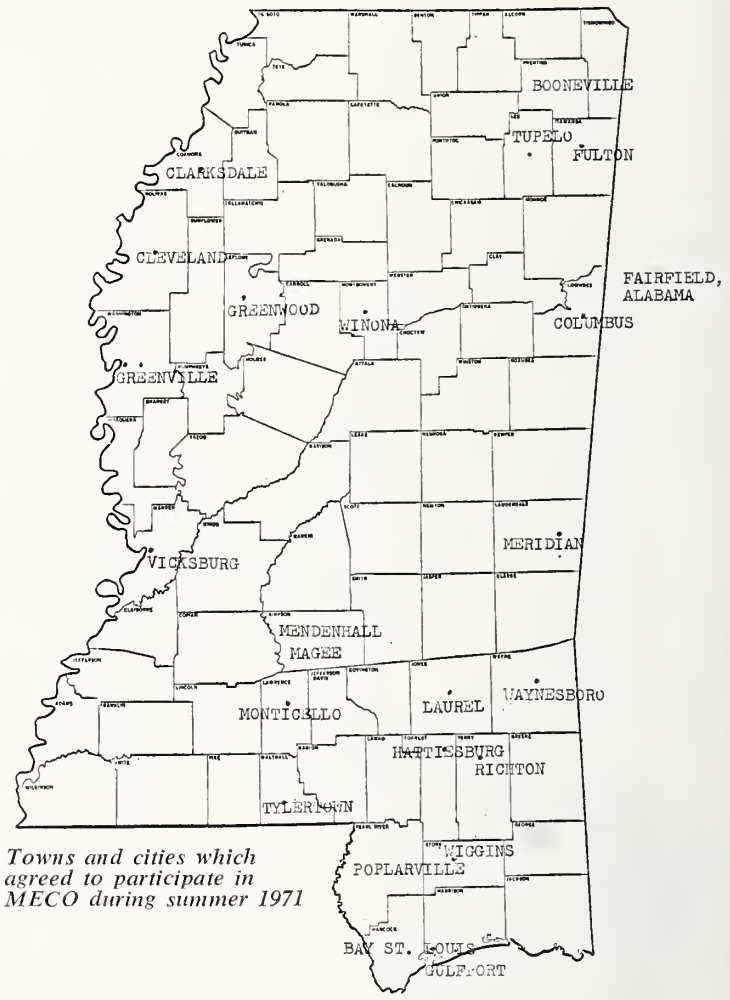
The program is a project in which the practicing physicians and community hospitals in all parts of the state can become involved and utilized efficiently in the undergraduate education of medical students.

At the same time, the communities, local hospitals and clinics have at their disposal a proven, effective program that will attract future physicians to practice in their areas.

Since nearly the entire medical education takes place in a large urban teaching hospital, MECO is designed to expose the future physician to the actual benefits of working and living in non-urban Mississippi. MECO will broaden the student's medical education by introducing him to rural hospitals, clinics and private practice's problems.



SAMA officers are busy making plans for the second summer of the MECO program. From left are chapter president Jim Alexander of Long Beach, MECO school director Wayne Hughes of Hattiesburg, MECO coordinator David Irwin of Saltillo, and state director Tom Greer of Starkville.



Towns and cities which agreed to participate in MECO during summer 1971

For a 10-week period during the summer the student is rotated throughout the medical services, hospital administration and the doctors' offices in the community. The educational and orientational details of the summer program for each

student are tailored to fit the specific community by the local hospital medical staff, the hospital administration and the local physicians.

The program is extremely flexible and can vary from an instructive rotating preceptorship in a community hospital to a 10-week assignment in a small group practice clinic.

To defray personal expenses, the medical student should receive a $750 stipend for the summer. The stipend is generally paid by the hospital or clinic to which the student devotes most of his time. Often local medical societies and community service organizations recognize the benefits of the MECO program and contribute a portion of the stipend.

MECO is designed to be an integral part of the medical education experience for students. Students participate because they want to be exposed to and learn the skills of actual medical practice; therefore, the medical student is to be used accordingly (and not just as an extra orderly). The student should be on-call during off-time in the event that his services are needed or that an educationally interesting situation develops.

Last summer 23 Mississippi hospitals ranging in bed capacity from 20 to the largest in the state took 36 medical students to get this annual program off to a successful start. The participating hospitals included: East Bolivar County Hospital, Cleveland; Jones County Community Hospital, Laurel; Hancock General Hospital, Bay St. Louis; Memorial Hospital, Gulfport; Lowndes General Hospital, Columbus; and Northeast Mississippi Hospital, Booneville.

Also Lawrence County Hospital, Monticello; Itawamba County Hospital, Fulton; North Mississippi Medical Center, Tupelo; Mercy Hospital-Street Memorial, Vicksburg; East Mississippi State Hospital, Meridian; Walthall County General Hospital, Tylertown; and Coahoma County Hospital, Clarksdale.

Others are Forrest General Hospital, Hattiesburg; Stone County Hospital, Wiggins; Tyler Holmes Memorial Hospital, Winona; King's Daughters Hospital, Greenville; Wayne General Hospital, Waynesboro; Perry County General Hospital, Richton; Pearl River County Hospital, Poplarville; Greenwood Leflore Hospital, Greenwood; Simpson County Hospital, Mendenhall; and Magee General Hospital, Magee.

SAMA officers in charge of the MECO program for 1972 are Tom Greer of Starkville, state director; Jim Alexander of Long Beach, chapter president; Wayne Hughes of Hattiesburg, MECO school director; David Irwin of Saltillo, MECO coordinator; and Tom Allen of Vicksburg, regional representative.

Advanced Rhinoplasty Workshop Scheduled

A workshop in Advanced Rhinoplasty will be held Feb. 27-March 3, 1972, at the department of otolaryngology, Baylor University College of Medicine, Houston, Tex.

Sponsored by the American Academy of Facial Plastic and Reconstructive Surgery, Inc., the workshop is for experienced surgeons who already perform this procedure but seek additional and more exhaustive instruction at advanced level.

Priority will be given to surgeons actively engaged in teaching. A registration fee of $500 will be charged.

For further information, contact: Dr. William K. Wright, Director, Suite 508, Hermann Professional Building, Texas Medical Center, Houston, Tex. 77025.

SBH Warns Hunters About Tularemia

Dr. Durward L. Blakey, director of the State Board of Health division of Preventable Disease Control, has issued a warning to hunters about tularemia, a disease which humans acquire from wildlife.

This disease is commonly called "Rabbit Fever" and has been associated with rabbits. It is also transmitted by squirrel, skunk, woodchuck, muskrat, opossum and most other wild mammalian animals.

The most undramatic mode of transmission, added Dr. Blakey, is by vectors which are biting and blood sucking insects, especially ticks, which are numerous this time of year.

Symptoms of tularemia in man appear in about two to seven days following the bite of the bacteria-carrying insect or exposure to a diseased animal. Sudden chills, fever, headache, vomiting, sweating, weakness and body pains are the most common symptoms.

At the point of entry for the organism through the skin, an ulcer frequently forms. When the hand or arm is the initial point of attack, the lymph nodes of the elbow and axilla become swollen and painful, said Dr. Blakey.

The fever is often high throughout the course of the disease and may persist at 102-104 for several weeks in some cases. Complete recovery often takes three to six weeks.

With the availability of antibiotics, treatment of tularemia is usually successful now.

Dr. Guyton Named to Heart and Lung Council

Dr. Arthur C. Guyton, physiology and biophysics chairman at The University of Mississippi School of Medicine, has been named to the National Heart and Lung Advisory Council of the National Heart and Lung Institute, announced Dr. Robert Q. Marston, National Institutes of Health director.

An international authority on the physiology of the cardiovascular-respiratory system, Dr. Guyton will meet with the council three times yearly to help evaluate NHLI research and training programs directed against cardiovascular and respiratory diseases. During his four-year term, he will also make recommendations on NHLI program goals, directions and priorities.

Dr. Guyton, a University of Mississippi graduate, earned the M.D. at Harvard University. He has chaired The University of Mississippi School of Medicine Department of Physiology and Biophysics since 1948.

CAP, ASIM Offer Proficiency Testing

In a collaborative effort, two national medical specialty societies have joined together to offer a proficiency testing program to physicians with office laboratories.

The American Society of Internal Medicine and the College of American Pathologists have designed PEP (Proficiency Evaluation Program) specifically for monitoring the capabilities of the physician's office laboratory and for conducting an economical, comprehensive evaluation of his own test results.

In announcing the joint endeavor, ASIM President, Dr. Otto C. Page, of Portland, and CAP President, Dr. C. A. McWhorter, of Omaha, said that the two specialty organizations decided to offer the program jointly as evidence of medicine's desire to establish a peer review program for physicians that really works.

Dr. McWhorter emphasized that "participation in the proficiency testing program is entirely confidential. The physician receives data which compares the performance of his laboratory to a peer group comprised of all participating physician office laboratories."

Dr. Page said that "the ASIM agreed to a partnership with the CAP in this venture because of the College's broad experience with quality evaluation programs for clinical and hospital laboratories. We have seen how the CAP's programs have given directors of laboratories and clinicians the assurance of quality results. Now we want physicians with office laboratories to have a program that assures their patients, personnel, and third parties, such as government, of the quality of test results."

Physician-subscribers are sent test materials and instructions quarterly for their personnel. The test results obtained by the office laboratory then go to an impartial computer processing center. There, results are matched and compared to those obtained for the same tests, by reference laboratories and other physicians' office laboratories, and finally a confidential report is returned to the physician.

Weems Mental Health Center Is Underway

Construction is now underway on the Weems Community Mental Health Center in Meridian.

The mental health facility when constructed will climax a six-year effort of planning and work by numerous local and area mental health leaders. The $250,000, 7,000 square foot facility will serve Lauderdale, Kemper, Neshoba, Clarke, Newton, Scott and Jasper counties and will be administered by the Region 10 MH/MR Commission.

The facility, being constructed with a combination of local and federal community mental health funds, is located on the access road which runs between Meridian Junior College and 20th Street extension, adjacent to the main complex of East Mississippi State Hospital.

A federal staffing grant for support of an interdisciplinary staff for the center has been approved and is awaiting funding. Dr. William M. Wood of Meridian is administrative psychiatrist.

In the meantime, outpatient services on an interim basis are being supported by local tax funds of the seven county area.

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Jaycees Open Evaluation Center

Since July 1, comprehensive evaluation services for identification of unique needs of children with all kinds of handicaps have been offered at Ellisville State School. The program is being carried out at the Jaycee Evaluation Center which is funded by the Mississippi Junior Chamber of Commerce, the Regional Deaf-Blind Program and by Ellisville State School.

The function of the Jaycee Evaluation Center is to (1) identify the needs, strengths, and level of functioning of each child, (2) develop a program to meet these individual needs, (3) assist the parents of the child in recognizing these needs and developing techniques they can use in the training and development of their child, (4) assist parents in the location and utilization of all the appropriate community resources.

The staff of the center functions as a multidiscipline team. Referrals are made directly to the Evaluation Center rather than to specialists, so the decisions regarding remedial activities and programs are comprehensive. This also enables parents to have one point of inquiry to look for help rather than having to follow a typical referral cycle of uncoordinated services from many different directions.

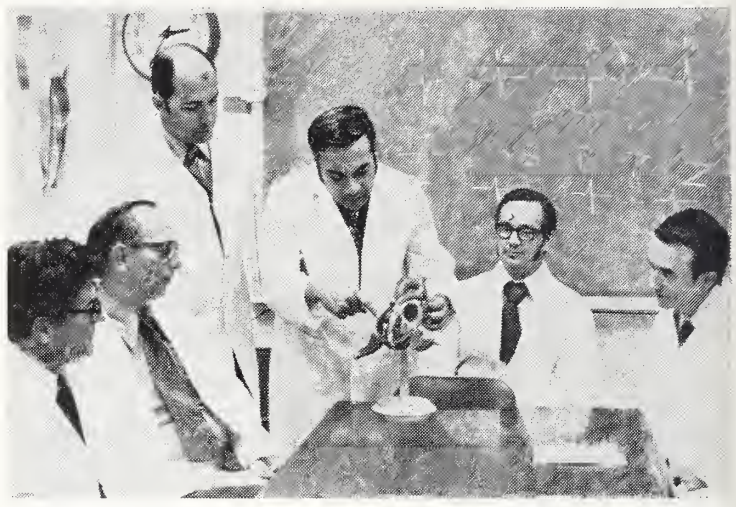
In the initial stages the Jaycee Evaluation Center is providing services in six major areas: (1) medical, including neurological, ophthalmological, and others as needed; (2) social, (3) child development, (4) psycho-educational, (5) speech and language, and (6) audiological. All of these services function primarily to assist the parents in developing insight into the needs of the child in an effort to promote efficient learning and optimal development of their child. The center staff will recommend and assist the parents in the effective utilization of programs designed to remedy or cope with the child's problem.

The Jaycee Evaluation Center will serve the handicapped population throughout the entire state, but due to the location and staff limitations, will only provide direct follow-up services by the center staff in the community and home for the general southern half of the state. The staff will assist parents throughout the state in obtaining available community resources.

The child must be accompanied by a parent or guardian for the entire evaluation period. The minimum evaluation period will be three days at the Evaluation Center. Typically the evaluation will last for a full five-day week. At the present time there is no charge for the Jaycee Evaluation Center services to legal residents of the state of Mississippi. Meals and a two-bedroom suite are provided for the child and his family.

Further information may be obtained by writing or calling the Jaycee Evaluation Center, Ellisville State School, Ellisville, Miss. 39437.

Five Physicians Take EKG Course



Five family physicians from across the state took a week-long intensive refresher EKG course at the University Medical Center in Oct. One of eight different courses offered twice during the year, the class is part of the Mississippi Postgraduate Institute in the Medical Sciences. The Mississippi Regional Medical Program provides grant funds. At third right, medicine instructor Dr. Gaston Rodriguez lectures to the group. Registrants included, from left, Drs. Frank Wade of Magee, J. A. Poole of Centreville, Charles Hollingshead of Laurel, Charles Williams of Jackson and John Estess of Hollandale.

Cardiologists Plan 1972 Scientific Session

The American College of Cardiology (ACC), the national medical society for specialists and research scientists in cardiovascular diseases, will hold its 21st Annual Scientific Session in Chicago, March 1-5, 1972 at the Conrad Hilton.

The 1972 session is described as a "distinguished program of continuing medical education" by Dr. Forrest H. Adams, Los Angeles, ACC president, and Dr. Dean T. Mason, Davis, Calif., scientific program chairman.

The college also plans to have a self-assessment classroom, more than 300 scientific and technical exhibits and premiere showings of new films on cardiovascular research and patient care.

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IN CONCLUSION

The great detergent debate still rages, becoming all the more confusing as the Environmental Protection Agency has flip-flopped and restored phosphates to good graces. Held to be a major source of pollution, phosphates were being phased out of detergents in favor of nitrilotriacetate (NTA). Researchers found NTA worse than phosphates because of ability to attract toxic metals like cadmium and methyl mercury. Action is costing industry hundreds of millions.

Mason Lustig of Long Island qualified for welfare and Medicaid, but promptly got kicked off when his picture appeared in newspapers. Mason's application said he has two sons posing support problem. The trouble is that Mason is a Great Dane, and sons Bo and Rip are 100-pound puppies. Owners filed application to demonstrate laxity of welfare administration, receiving wide publicity. But New York officials aren't laughing, and have turned matter over to DA.

American Cancer Society, in partnership with organized labor, is sponsoring $1 million study of exposure to suspected carcinogens in industry. Investigators are Dr. Cuyler Hammond of tobacco hazard studies and Dr. Irving Selikoff, noted Mt. Sinai researcher. ACS feels that millions of American workers in industry are exposed to cancer-producing chemicals and ionizing radiation. Project will report safe work environments as well as hazards, ACS says.

California Medical Association referendum on compulsory AMA membership - they call it "unified" - produced 3-to-2 vote to pay AMA dues. Response from giant society's 25,000 members was 65.6 per cent or 16,334 replying. About 10,000 voted AMA support. Poll has been questioned, however, especially as to 34.4 per cent not voting. Referendum is advisory to House of Delegates who postponed decision on retaining compulsory AMA membership requirement pending results.

Health Insurance Council has revised standard uniform claim form for payment of physicians' services. Approved by AMA Council on Medical Service, new form has only 13 items in brief, one-page format. MSMA has supplied HIC form to physicians at cost for years and will be adopting new revision in near future. Form is accepted by all member companies of Health Insurance Association of America and Health Insurance Council.

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Mississippi state medical
association. Journal.
v.12, 1971.

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